DOCUMENT RESUME

ED 338 955 CG 023 766

AUTHOR O'Callaghan, J. Brien
TITLE School-Based Collaboration: Constructing a Partnership That Works.
PUB DATE 91
NOTE 151p.
PUB TYPE Guides - General (050)

EDRS PRICE MF01/PC07 Plus Postage.
DESCRIPTORS *Counseling Techniques; Elementary Secondary Education; Family Problems; *Interdisciplinary Approach; Intervention; *Parent School Relationship; Preschool Education; *School Community Relationship; *School Counseling; Student Problems

ABSTRACT

This guide is designed for therapists who are looking for faster, more reliable ways of preventing and solving child problems. It focuses on the variety of family-school collaboration that is school-based and involves interaction between families, school, and community agencies. Chapter 1 presents a collaborative model called FACETS (Families and Agencies Collaborating in Ecosystemic Teams in Schools) for working with families in schools. Within the FACETS model of child problem-solving there is a progression of intervention steps or stages from simple procedures involving only the teacher and student to more complex ones. Chapter 2 makes the case for greater collaboration between child caretakers, particularly between parents and school personnel. Chapter 3 discusses step six of the FACETS model, the Collaborative Team Intervention. This intervention involves a meeting of the student, school personnel, community workers and personnel, and family members. Case studies from preschool, elementary, middle, and high school levels are presented in chapters 4 through 7. Chapter 8 discusses eight obstacles in the path of the systems therapists and school coordinators who become interested in establishing a school-based collaboration program for children. This chapter also presents seven guidelines or suggestions as directives for those interested in establishing collaboration in schools. Chapter 9 discusses the effect of the collaboration approach on school personnel and climate, and on the community. In chapter 10, steps are outlined that must be taken if family-school collaboration is to move from the level of pilot project to that of prioritized standard practice. A bibliography is included. (ABL)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED 338955

School-Based Collaboration: Constructing a Partnership That Works

J. Brien O'Callaghan, Ph.D.

CG023766

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☐ This document has been reproduced as received from the person or organization originating it

☒ Minor changes have been made to improve reproduction quality

- Points of view or opinions stated in this document do not necessarily represent official OERI position or policy

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY
J. Brien O'Callaghan

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

BEST COPY AVAILABLE

Table of Contents

Chapter		***Page***
Introduction		1
One	Working with Families in Schools: The Collaborative Model	3
Two	Automatic Pilot Parenting: Teaching Children to Raise Themselves	16
Three	The Collaborative Team Intervention (CTI): Orchestrating the Larger System	31
Four	Case Studies: Pre-school	48
Five	Case Studies: Elementary School	59
Six	Case Studies: Middle School	82
Seven	Case Studies: High School	94
Eight	Establishing & Implementing a Collaboration Program: Obstacles & Blueprints	108
Nine	Beyond the Child and the Family: Impact on Schools and Communities	116
Ten	The Future of School-Based Collaboration: In the End, a Question of Leadership	121

Figures

Figure 1: The School Decision Chart 9

Figure 2: CTI Attendance List 14

Figure 3: Universe of Parent Behavior 21

Figure 4: Universe of Child Behavior 22

Figure 5: Child Behavior Locus of Control 24

Figure 6a: Daily Report Card - Elementary 43

Figure 6b: Daily Report Card - Middle School/High School 44

Introduction

The notion of increasing communication and problem-solving efforts between the family and the school in the interest of better education and child development has been getting increasing attention in recent years. Since Harry Aponte published his seminal article in Family Process (Aponte, 1976), dozens of researchers and writers have published over 200 articles, books, and audio cassette tapes on this subject, which has generally come to be called, "Family-School Collaboration." This book is designed to be a guide for therapists who are looking for faster, more reliable ways of preventing and solving child problems and to focus on one kind of family-school collaboration, namely that variety that is school-based and involves interaction between families, school, and community agencies. It may also be a helpful resource for school professionals, parents, and others.

What is "school-based" collaboration? Webster defines "collaboration" as "the act of working together." Using the widest interpretation of this definition, it might be said that families and schools have always "collaborated," i.e., worked together. But what is necessary today, and what is not occuring in most communities, is a more focused and sharper interpretation of collaboration which involves many "c" words, e.g., communication, coordination, cooperation, and candor. In this latter sense, in this writer's opinion, collaboration between families, schools, and community agencies is rare, and its absence is the principal reason, after parenting incompetence, for the development and maintenance of social and academic problems in children. It is also the opinion expressed here that collaborating within the school setting significantly enhances the collaboration process.

It is my hope that in reading this short text, many therapists of children will move beyond the temptation to blame and feel helpless to a position in which they feel empowered to make things better - NOW. In these days of drugs, divorce, and depression, school-based collaboration offers perhaps the best hope for the solution

© Copyright 1991 by Collaborative Solutions, Bethel, CT. All rights reserved.

of many problems unresponsive to independent family, school, and community efforts.

This present work represents the results of thinking, reading, and clinical work over the past 25 years, particularly the results of the implementation of the FACETS™ school-based collaboration model in Connecticut school systems. Over 250 families have participated in the 1-3 session Collaborative Team Interventions (CTIs) described in this book. It is my hope that, through the descriptions and stories that follow, many therapists will be able to find a way to be more helpful to the children that we have been blessed to live with and enjoy.

Chapter One

Working With Families in Schools: The Collaborative Model

The notion of collaborating with families and school personnel in the treatment of children who are experiencing difficulties in school is not new or unusual for a systems or marriage and family therapist. Many referrals to the therapist may originate with school personnel, e.g., the school social worker, and the "systems" therapist, by definition, is interested in working with the system in which the child lives. Debate and controversy begin to occur, however, when the extent and form of therapist-school -family collaboration are considered.

Because of his or her commitment to accessing the system in the interest of the child, the systems therapist usually has a more liberal and flexible interpretation of the concept of confidentiality than does the traditional, individually-focused, therapist. The systems therapist usually asks the permission of the family not only to acknowledge the arrival of the referred child and family but to talk with, to "collaborate" with, school personnel in the treatment of the school problems of a child, at least by phone. In addition, it probably would not be unusual for a systems therapist to meet at school, a clinic, or a private office with a school representative to discuss a child or to attend a Planning and Placement Team (PPT) meeting in school. What is not generally the practice of the systems therapist is a more intense and open variety of school-based collaboration in which the family, school personnel and, sometimes, community representatives collaborate together under the direction of the systems therapist.

Rationale

It is the thesis of this book that therapist directed school-based collaboration between family, school, and community is an idea or model that merits increased attention from the marriage and family profession, school leaders, families, and society at large. Some of the supports for this position are as follows:

1. Children are being abused and neglected in record numbers. In a Time article (10/8/90), "Shameful Bequests to the Next Generation," the following grim statistics were provided on the life of the American child:

> "Every eight seconds of the school day, a child drops out. Every 26 seconds, a child runs away from home. Every 47 seconds, a child is abused or neglected. Every 67 seconds, a teenager has a baby. Every seven minutes, a child is arrested for a drug offense. Every 36 minutes, a child is killed or injured by a gun. Every day 135,000 children bring their guns to school. Even children from the most comfortable surroundings are at risk."

In this same article, Robert Coles, noted Harvard psychiatrist, was quoted as saying, "Children who go unheeded ... are children who are going to turn on the world that neglected them." And Marion Wright Edelman of the Children's Defense Fund added, "The inattention to children by our society poses a greater threat to our safety, harmony and productivity than any external enemy."

2. Schools are frustrated with the lack of success of individual interventions with difficult students and families. Despite the use of a large repertoire of individual strategies like individual assessment and counseling, peer counseling, group counseling, drug curricula, and residential placements, the rates of drop-out, illiteracy, suicide, and pregnancy continue to be essentially unaffected. Less than 50% of American children graduate from high school able to read and write.
In baseball, batting .500 is superb, but by school or parenting standards, this is failing. It is just not acceptable by any standard to have 1 out of 2 kids functioning unsuccessfully

in school.

3. The marriage and family therapist is also experiencing frustration as families continue to dissolve and malfunction in the 1990s. Office-based practice is decreasingly an option for highly stressed single parents, step- and two-career families who have less time, money, and patience for therapy, no matter how much they may need it.

4. For the school and the therapist, the help available from community agencies like the police, the courts, and public social agencies is often seen as extremely limited and of last resort.

5. For the community agency, there is a feeling of lack of coordination and the inability to do anything of more than short-term benefit, e.g., the referral of a child to residential treatment.

6. Families, for their part, are absolutely desperate and are open to any source of help, particularly if it is low-cost and based in a familiar, trusted setting.

For these and other reasons, schools are opening the door to some variety of collaborative effort.

Need For Collaboration

Chapter 2 will present the case for a way of thinking and acting by child caretakers that can lead to greater success with children. In this chapter, the case will be made for greater collaboration between child caretakers, particularly between parents and school personnel. Parents and school personnel are generally well-intentioned and do many things right. When acting separately, however, they are more likely to make crucial caretaking errors with varying degrees of unfortunate results in child dysfunction. These dysfunctions can be observed at home or school or in both locations, as well as in the community. At home, parents are busier and more stressed than ever because of divorce, economic pressures, and other factors, and are often less actively involved than in recent decades in the supervision of their children. When they sense the onset of child problems they are more likely to deny the problems or be too embarrasssed or overwhelmed to ask for help. At school, teachers and support staff spend much vaulable time and energy trying to motivate the student independent of family involvement.

There seems to be an entrenched commitment in today's schools, especially in the upper grades, to the individual or "intrapsychic" intervention model involving individual assessment and counseling, group counseling, peer counseling, and other such individual-focused procedures. When individual measures fail to produce improvement, school personnel sometimes spend weeks "beating around the bush" trying to avoid offending parents or incurring responsibility for costly therapy outside of school. There exists in many schools what might be called an "inverted decision chart" in which the first thing that should be done, i.e., discussion with parents, is done last, after exhaustive individual efforts with the problem child.

The Family-School Relationship

A helpful analysis of patterns of family-school relationships has been provided by Tom Power and Karlotta Bartholemew in the 1987 article, "Family-School Relationship Patterns: An Ecological Assessment" (Power & Bartholemew, 1987). In this article, the authors describe five relationship patterns: Avoidant, Competitive, Merged, One-Way, and Collaborative. The first four of these patterns, as the labels suggest, are essentially dysfunctional. The authors recommend the "Collaborative" relationship between family and school in which "Parents and teachers exercise ultimate authority in their respective domains," and "... are involved reciprocally in a working alliance." In the first four family-school relationship patterns, families and schools mismanage what Minuchin has called "boundaries" in relationships (Minuchin, 1974). The "collaborative" relationship between home and school allows for honest interactions about the adult issues which are maintaining the dysfunctional child "job assignment" in school. This exchange of information can then lead to the formulation of effective joint home-school solutions.

The Family-School Collaboration Model

In contrast to the individualistic and intrapsychic school model of assessment and intervention, an "ecosystemic" model of consultation or collaboration between family and school began to develop in the mid 1970s. Aponte (1976), Tucker and Dyson (1976) and others, e.g., O'Callaghan (1975), described intervention formats in which schools and families worked together on child problems under the direction of a family systems consultant. In the past decade and a half, at least 200 articles have appeared in various therapy and educational journals advocating or describing the use of collaborative working relationships and formats. A list of articles and tapes on the topic of family-school collaboration is provided in Appendices A and B.

A review of the literature (printed and tape) on family-school collaboration reveals that most of the articles focus on a description of systems thinking as provided by von Bertalannfy (1968), Bateson (1972), and by some of the early family therapists, e.g., Haley, J. & Hoffman, L., Eds. (1968) and on theoretical or practical applications of systems principles to schools, e.g., Nicoll (1984) and Worden (1981). Some articles, e.g., Aponte (1976), describe specific "ecostructural" or collaborative intervention strategies. Still others present a model of collaborative intervention, e.g., Lusterman's (1985) "interdictive" model. In addition to attention to the why and how of family-school collaboration, some few presentations describe extensive organized school collaboration programs, e.g., Fine, M.J. (1984). Most of the organized programs, however, involve referral of the problem child to clinics outside the school.

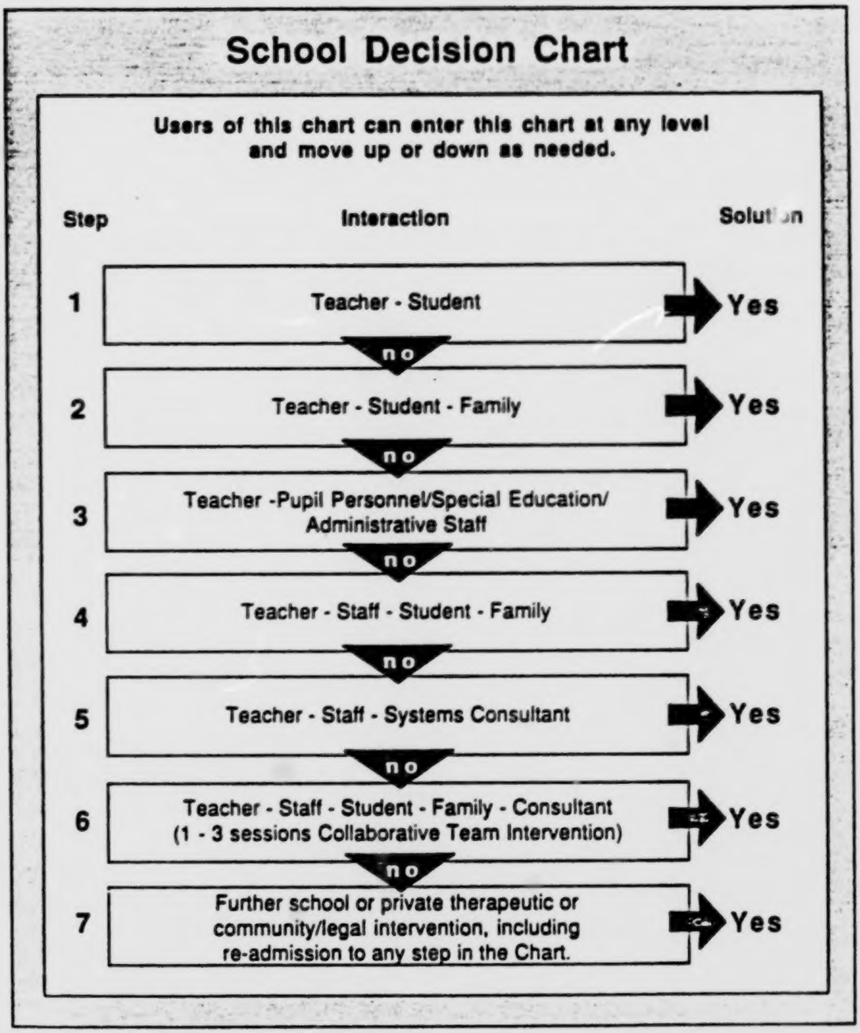
FACETS:

A school-based ecosystemic model of family, school, and community collaboration

In the Spring of 1983, this author began doing family interventions in schools with school personnel present in the room. This practice began as an extension of in-service training of school staff in family systems theory and was greatly influenced by my earlier seven years of work as a teacher and guidance counselor at the senior high school level. From the beginning, the family interventions in the schools were designed to serve two complementary functions, staff training and child problem remediation. The child problem to be addressed could be of any variety educational, behavioral, or psychological - and any age child was eligible for referral. Originally called "family-school consultation," the name gradually changed to "family-school collaboration' (O'Callaghan, 1988, 1989, 1990) and more recently to FACETS™ (Families and Agencies Collaborating in Ecosystemic Teams in Schools). The switch to the FACETS title was motivated principally by the need to recognize a standard feature of the program not conveyed by previous program titles, namely, the active involvement of community agencies like the Juvenile Division of the Superior Court and various other practitioners like private therapists. Since 1983, several school systems in Connecticut have employed the collaboration model. To date, over 250 one -to-three "collaborative team interventions" have been personally conducted by this author in schools. Other school personnel trained in this model, as a group, have conducted a similar number of CTIs.

The School Decision Chart

"The Decision Chart for Intervention with Child Problems in Educational Settings", or more simply the "School Decision Chart" (SDC), is presented in Figure 1.


School Decision Chart
Users of this chart can enter this chart at any level and move up or down as needed.
Step
Interaction
Solution
1
Teacher - Student
Yes
no
2
Teacher - Student - Family
Yes
no
3
Teacher -Pupil Personnel/Special Education/ Administrative Staff
Yes
no
4
Teacher - Staff - Student - Family
Yes
no
5
Teacher - Staff - Systems Consultant
Yes
no
6
Teacher - Staff - Student - Family - Consultant (1 - 3 sessions Collaborative Team Intervention)
Yes
no
7
Further school or private therapeutic or community/legal intervention, including re-admission to any step in the Chart.
Yes

The Decision Chart is provided as a useful structure for efforts to solve child academic, psychological, and behavioral problems. Interactions are communications designed to produce successful solutions.

Figure 1: School Decision Chart

The School Decision Chart depicts a progressive flow of school-based intervention in the service of child problem resolution. The SDC calls for the active ownership of responsibility for child success, primarily by the teacher and secondarily by school support staff, such as school psychologists and school social workers. It also calls for the early involvement of parents and other family members, and the progressive and swift involvement of other players like community agency personnel when problem resolution is not forthcoming. The interval between intervention steps is usually 1-2 weeks, in contrast to what are often much longer intervals in prevailing school intervention practices. In the FACETS model, children are identified early, the family is involved within one week of problem identification, and new players are added to the process weekly until a solution is reached. Steps in the intervention process are sometimes skipped or repeated as practitioners become more familiar with how the model works best for them.

School Decision Chart:
A Case Example

The steps of the School Decision Chart call for an increased teacher awareness and use of systems priniciples, earlier and more open involvement of families in school problem-solving efforts, the prompt and progressive assembling of larger groups of relevant "players," and the use of a systems therapist in school in 1-3 sessions "Collaborative Team Interventions" when school procedures are not succeeding. The approach outlined in the "School Decision Chart" has been used successfully in Connecticut school systems over the past eight years.

An example of a collaborative systems intervention using this chart is provided below:

Mark was 15, an 8th grader, who had moved to a rural town from a big city only a week ago. He was already in trouble. He had had a physical fight with another student, and the teachers thought he was distant and might have deeper problems. There was only one month left in the school year, and school officials could most likely have weathered the problem and waited to reassess it next year. They could also continue to use various individual procedures like detentions and suspensions or individual in-school counseling, or they could refer Mark to a therapist outside the school. Instead they chose to invite the student and his family into the school to meet with school staff to work on the problem together in a "collaborative team intervention."

Step 1

In addition to the imposition of a detention, Mark's middle school teachers all talked with him individually about the fighting incident and about what might be bothering him.

Step 2

When Mark was uncooperative with the teachers, the parents were invited to school for a conference. The interview revealed that Mark's mother was re-married and that she had a serious problem managing Mark.

Step 3

Because there were indications of significant home problems, the teachers requested a "strategy meeting" with the school social worker, the guidance counselor and the principal. Because of the seriousness of the parent-child conflict and because school would be closing in three weeks at this point, a decision was made to skip Steps 4 and 5 in the decision chart and to schedule a Collaborative Team Intervention with the professional systems therapist/consultant. It was hoped that the 1 - 3 professionally conducted in-school sessions might be helpful to the family, and that the family might continue with some therapist privately over the summer prior to the student's admission to high school.

Step 6

The first collaborative meeting was attended by Mark, his brother and sister, ages 9 and 6, his stepfather, his father and his father's girlfriend, his teachers, the school social worker, the guidance counselor, the principal, and the systems consultant. It became clear at this meeting that Mark's mother and Mark had been physically abused by Mark's father prior to the parents' separation, and that Mark was caught in the middle of a continuing battle between his parents. It was also clear that Mark's mother lost her temper easily, which triggered Mark into physical and emotional behavior like his father's his mother's. The consultant diagnosed Mark's problem as primarily a "motivational deficit disorder," stemming from several dysfunctions in the behavior of his parents. The parents decided to begin family therapy privately with the school consultant.

Step 7

Private therapy began with the school consultant. Mark's violent behavior became more manageable as his parents became more calm and cooperative with one another. Continuing problems at the high school were handled collaboratively between the high school and the systems consultant.

The Ecosystemic Consultant

The ecosystemic consultant is an expert in the analysis of, and intervention with, the family and other systems, like schools. This person is probably a marriage and family therapist, certified by The American Association for Marriage and Family Therapy, who has experience working with school personnel regarding child school problems. The systems consultant is brought into school when the utilization of Steps 1-4 of the School Decision Chart have failed to produce a solution to the child's problem. The introduction of the consultant can occur at Step 5, a "strategy meeting" with school staff. In this step, the child, family, and other outside players are not present. When school staff have been trained in the FACETS approach, and when they are more comfortable with the systems consultant and the model, the consultant may be brought into the system directly at Step 6 to conduct what is called the "Collaborative Team Intervention" (CTI). In this step, because many previous attempts to solve a child's problem have failed, invitations are extended to many relevant parties to attend the meeting.

It is the task of the ecosystemic consultant, whether brought into the school at Step 5 or 6, to provide a correct diagnosis of the child's problem and an effective treatment plan in one session. Sometimes, especially in Step 5, this may not be easy since some of the players, e.g., the family, may not be present. The consultant engages in a process of observation, listening, asking questions, probing, provoking, and other methods to accomplish his or her goal. In-service training of school staff and school commmitment to the use of the FACETS model are crucial variables in the effectiveness of this brief intervention model. The most important player besides the consultant is the school social worker or other school support staff member who is the "school coordinator" of the FACETS program and a valuable facilitator at the various sessions.

Chapter 3 of this book focuses on the theory and practice of collaborative team interventions and school strategy sessions.

CTI Players

As mentioned earlier, the list of participants at a CTI session, or even at a strategy session, may be a long one. The rationale for large attendance is that something more can be accomplished with everyone together than working with even all the same players separately. This can happen in a number of ways. Husband and wife dynamics can increase the clarity of family dynamics and the role of the child's problem in the family. The relationship between the teacher and the child and the teacher and the parent(s) can be observed by others. Finally, an increased level of frustration, tension, or motivation can be generated at a larger meeting which may result in statements or resolutions not otherwise possible. The examples given here are simply a few of the dozens that might be given. There are some things that are perhaps not said at large meetings, but smaller meetings have already been tried prior to Step 6, and they can always be tried again.

Figure 2 presents a list of some of the possible attendees at Collaborative Team Interventions.

COLLABORATIVE TEAM INTERVENTION (CTI) ATTENDANCE LIST

STUDENT

Child

Both Biological Parents

Siblings

Extended Family
(aunts, uncles, cousins, grandparents, etc.)

Stepfamily

Adoptive Family

Friends

Neighbors

SCHOOL

Teacher

Principal

Assistant Principal

Guidance Counselor

School Psychologist

School Social Worker

Special Area Teachers

Special Education Personnel

Classroom Aides

Teachers and support staff of siblings

COMMUNITY

Private Therapist

Juvenile Court Officer

Medical Doctor

Case Worker, Dept. of Children and Youth Services

Town Social Worker

Town Youth Service Officer

Day Care Center Workers

Religious Personnel

Police Youth Officer

Lawyers

This list is by no means exhaustive. As practitioners begin thinking in a "systems" way, they can add to this list creatively as needed.

Figure 2: CTI Attendance List

The School Coordinator

As mentioned earlier, the school coordinator of the FACETS program is a key player. He or she is usually a school social worker, school psychologist, guidance counselor, school adjustment counselor, or special education teacher. It is the coordinator's job to receive referrals, set up the collaborative meetings, and to maintain and facilitate communication with all parties involved. It is usually the school coordinator who first becomes interested in the collaborative model and who convinces his or her principal and central administration to use it on a pilot basis. It is essential for the school coordinator to be highly enthused with the systems model and to be a person who can carry on in the face of the high levels of pressure and negativity that can at times be directed from any sector of the collaborative system. The school coordinator will very likely aspire to conduct CTIs independently in school and to become successful at doing so.

Summary

It is the thesis of this book that most of the child problems the adult world is so upset about - drug and alcohol abuse, suicide, and other serious problems - are principally the result of caretaking errors, and more specifically the result of the failure of family, school, and community to adequately collaborate. It is hoped that the procedures and examples provided here help to explain a "collaborative" method considered as an alternative to current school intrapsychic practice.

Chapter Two

Automatic Pilot Parenting: Teaching Children To Raise Themselves

Before one can implement a school-based collaboration program, one must have a philosophy of child rearing and a set of practices that are effective and that become a kind of "curriculum" of collaborative interventions. The present chapter outlines a theory of child development, problem formation and parenting which may be used by systems therapists in their collaborative effort to re-structure family interactions and the interactions of the larger system.

Intrapsychic vs. Interactional Thinking

We all know that children are experiencing a lot of pain and are in a lot of trouble. Unfortunately, although most of us can agree that things are quite bad, we cannot agree on the cause. Various culprits have been suggested, e.g., neurological problems, poverty, prejudice, lack of opportunity, divorce, television, and other alleged agents of disadvantage or disability. It is one of the theses of this book that most of our attempts to solve child problems do not work very well because they share one crucial flaw: they rely on a conceptualization of the child problem as intrapsychic or intrasomatic, i.e., having to do with something inside the child's mind or body, as opposed to interactional, i.e., having to do with how a child is managed by adults, principally parents and school personnel. Further, they focus on changing the child, whose problems are principally the result of interactional training and mismanagement. Examples of intrapsychic and intrasomatic conceptualizations are attention deficit disorder, hyperactivity, learning disability, developmental delay, and allergy. In this book, the word "intrapsychic" is used to refer to all conceptualizations of body-mind causality. One key to improving the state of the child is to realize that child behavior is a job assignment from adults and to ask parents, school personnel, and other adult figures to do a better job of raising children. Unfortunately, this idea is unpopular because it involves inconvenience to adults and the changing of ingrained social and education practices.

Motivational Deficit Disorder

If intrapsychic thinking can be replaced by interactional thinking, then most child problems can be conceptualized as the result of caretaking dysfunctions, specifically the caretaking errors involving the imbalanced use of control and protection. The child caretaking errors of over- and undercontrol and over- and underprotection lead to various child problems including what is referred to here as Motivational Deficit Disorder or M.D.D. M.D.D. is a state of undermotivation in which a child is discouraged or has been given too much without having to work for it.

The concept of Motivational Deficit Disorder has been created by this writer to provide a more optimistic alternative to what might be called the "mis-diagnoses" of Attention Deficit Disorder (A.D.D.), Learning Disability (L.D.), and other D.'s that seem to be sweeping the nation. The use of the word, "misdiagnoses," is not designed to dismiss the existence of attending difficulties or learning differences. Rather it is used to dispute what might be considered an overstated power of these disorders to interfere with learning and to cause misbehavior. A.D.D. diagnosticians are guilty of circular reasoning by observing attention difficulties, calling them a disorder, and then attributing the difficulties to the disorder.

Another violation of logic is the prescription of medication for the treatment of A.D.D. Ritalin, Dexedrine, Phenobarbitol, and other drugs used to treat Attention Deficit Disorder and hyperactivity will have effects, sometimes quieting. After all, they are drugs. The occasional effectiveness of the drug, however, does not prove the existence of the disorder, since it is possible, e.g., that the same drug could affect any non-A.D.D. person in similar ways. There have also been many negative side effects reported following the use of various medications. A recent court case in Derry, NH, was resolved after three years in favor of the parents who said that more problems were created by Ritalin than were solved (The Union Leader, 8/7/91).

Medication is not necessarily the best approach. It is the experience of this writer that most children that are diagnosed A.D.D. and/or hyperactive, and currently or previously taking Ritalin or Dexedrine, have become quite manageable and calm without the use of medications in response to a change in parent/caretaker behavior, that is, utilization of more or less control or more or less protection by the caretaker. Purveyors of the "D" words (Disability, Disorder, Deficit) are unfortunately and inadvertently discouraging kids and adults from taking responsibility for their own behavior and are offering society what might be called "diagnostic lay-away plans" in which problem behavior is attributed to mysterious causes and in which solutions are either not achievable or are someone else's responsibility. These plans have to be paid off later at high interest rates, for example, through the incarceration or placement in rehabilitation facilities of people whose problems were much more manageable in their original form. The main result of diagnostic lay-away is, of course, Motivational Deficit Disorder, in which kids and parents are undermotivated to achieve because of a belief that the disability prevents them from doing so.

Parent Training Deficit Disorder

Overemphasis on A.D.D., L.D., and other disabilities, e.g., what might be called E.D.D. (Economic Disadvantage Disability) usually leads to undercontrol of children. Motivational deficits can also be caused by parents who overcontrol their children, expect too much from them, and insist on scheduling their lives, including when to go to bed, get up, and do homework. These are the "Great Santini" (movie by this name) adults who expect their children to be President of the United States and want them to salute when they go by. There are also parenting disorders of overprotection and underprotection. From early ages, children need to learn progressive self-regulation skills, and caretakers who interfere with this process are, again, asking for diagnostic lay-away plans in which children are called "bad seeds," "like this from birth," and blamed for problems the caretakers create. All of these caretaker control and protection disorders can be grouped under the headings of Parent Training Deficit Disorder (P.T.D.D.), Teacher Training Deficit Disorder (T.T.D.D.), or other adult training disorders. By shifting the "D" diagnoses to the adult world, focus is shifted to the adults who caused the problem instead of the kids who are the diagnostic victims.

Pseudo-Causes of Child Problems

In addition to L.D., A.D.D., and other problems of an allegedly neurological or educational nature, child problems have been attributed to many other pseudo-causes, for example, poverty, prejudice, divorce, the absence of fathers, and other significant factors. These factors, however, while they may exist, are conditions, not causes. Many poor children, victims of prejudice, father absence, and other conditions have been known to cope and succeed. Handicapped artists, for example, born with no hands, learn how to paint with their feet, and others born without hands or feet learn to paint with their mouths. Clarence Thomas, a nominee in 1991 for appointment to the Supreme Court, spoke of refusing to use his poor Georgia background as an excuse for the inability to achieve. Children achieve primarily because of adults who care, take charge, and are competent child managers. Turning the corner on today's child crisis requires prioritizing causes and cures. Only in this way can our limited resources in time and money produce successful outcomes.

Automatic Pilot Parenting

The goal of successful parenting or child caretaking is the adoption of a balanced approach of "control and protection on demand," i.e., the use of control and protection only when and as much as needed, leading to a state of "automatic pilot" behavior or self regulation in children. In this state of mind the child makes generally good decisions without parental interference and asks for help only when he or she needs it. Parents keep an eye from an appropriate distance and intervene, preferably by questions, only when necessary. "Parenting by Questions" is a powerful regulation device which stresses assessing a child's wishes and ability to take care of itself before overdoing protection or control. When a child has never developed self-regulation or has disengaged from it, caretakers need to provide either more or less control or protection to develop or re-engage it. A "Universe of Parenting Behavior" is presented in Figure 3 which displays four quadrants of parenting styles. These quadrants are created by relationships between two dimensions of parenting behavior, namely, protection and control, or "love and limits."

UNIVERSE OF PARENT BEHAVIOR

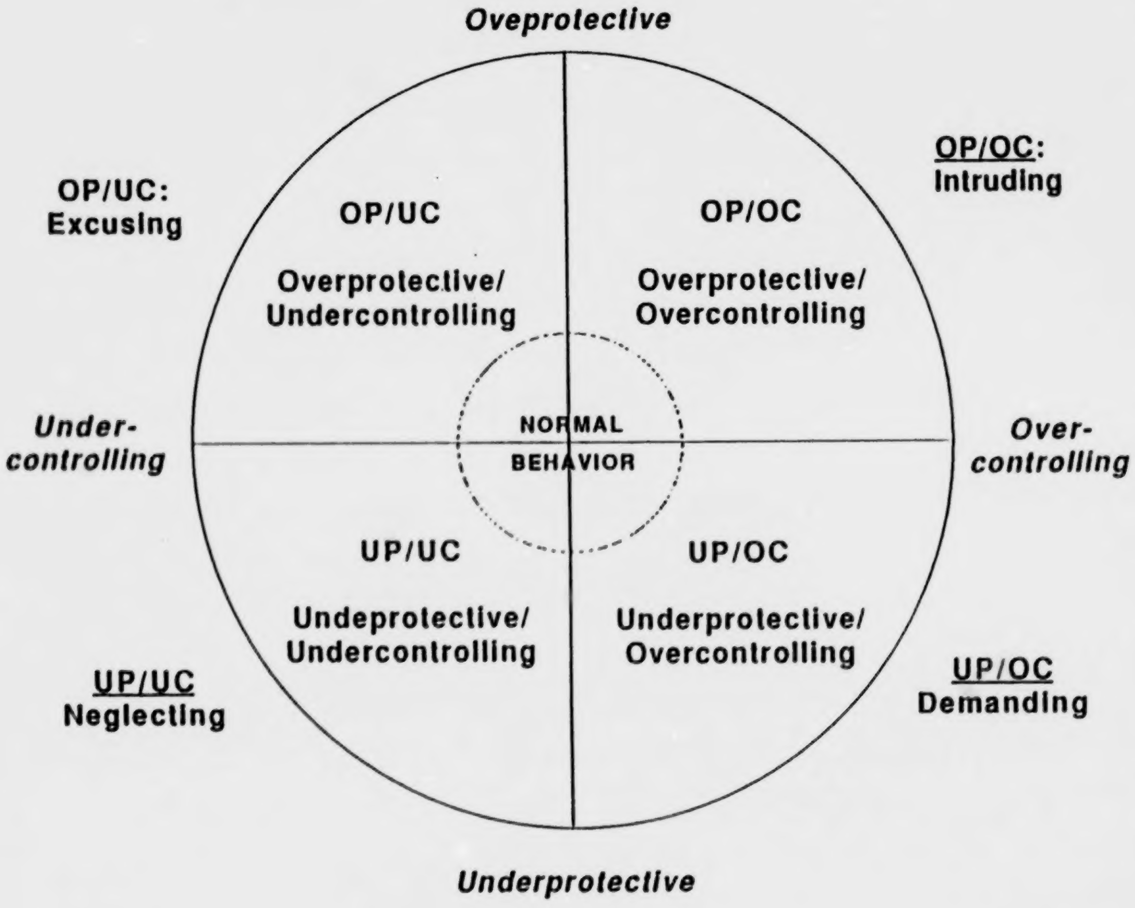


Figure 3: Universe of Parenting Behavior

The particular style of parenting behavior that is used by parents will have direct effects on the type of child behavior that is observed in their children. Dysfunctional child behaviors can be displayed in a "Universe of Child Behavior" which is given in Figure 4. The quadrants in this universe are created by relationships between two dimensions of child behavior, compliance and directness.

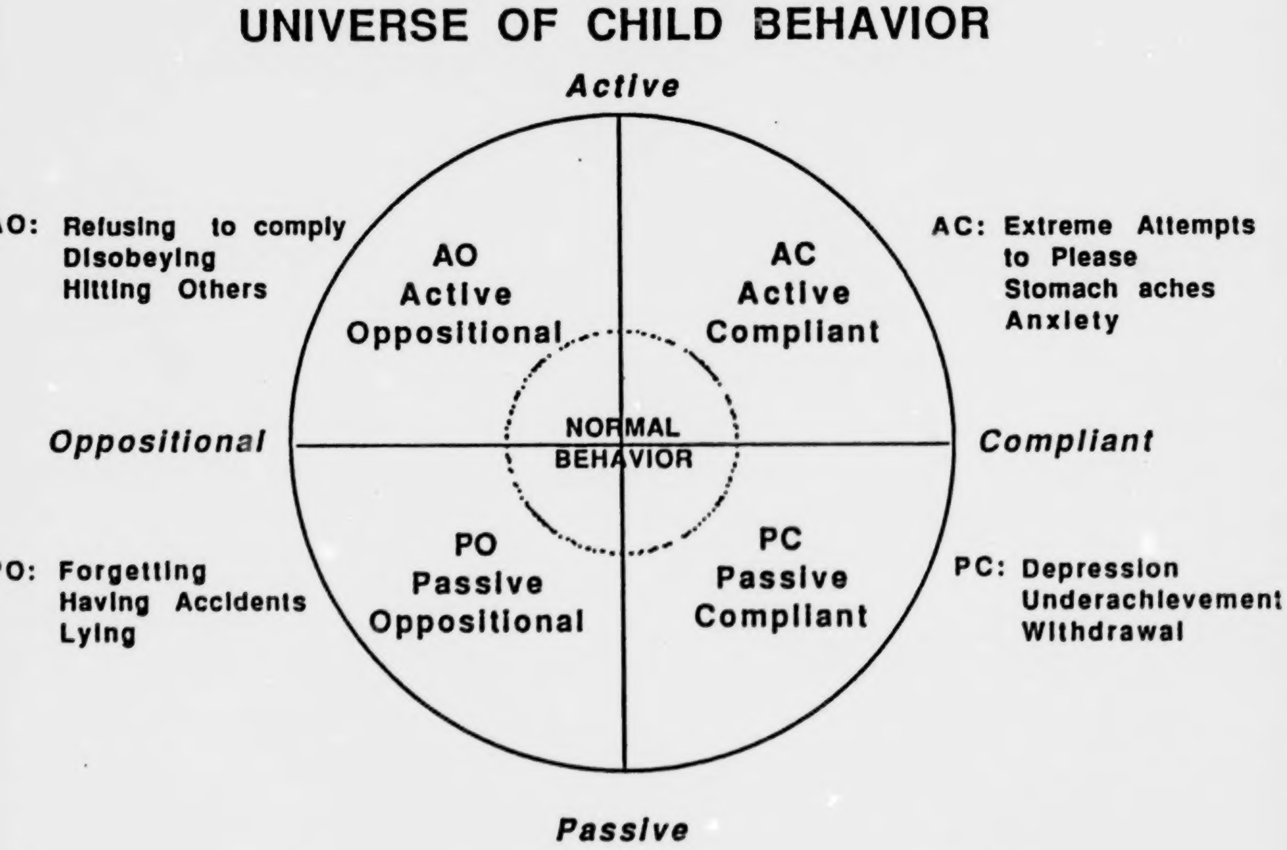


Figure 4: Universe of Child Behavior

The following is a description of the four varieties of dysfunctional parenting styles presented in Figure 3 and their relationship to the four dysfunctional child behavior styles presented in Figure 4.

1. The Overprotective/Undercontrolling (OP/UC) Parent

The overprotective and undercontrolling parent will attempt to mediate excessively between the child and the environment so that it doesn't get hurt. This parent will also let the child "get away with murder" so that it is not "traumatized" or hurt by parents' expectations. The problem with this dysfunctional style is that the child is deprived of experiencing the realistic boundaries of the physical and social world and, as a result, believes that it is invincible and in charge of the world. This child becomes a "spoiled brat" and a "terrorist," the "actively oppositional" (AO) child in Figure 4. The AO child will have little regard for anyone's wishes and be very obnoxious as a baby. It will become more and more unmanageable and disobedient until its parents or other adults protect it less and control it more.

2. The Overprotective/Overcontrolling (OP/OC) Parent

The overprotective, overcontrolling parent will again attempt to buffer the child from any hurt that might befall it but, in addition, this parent will attempt to limit a child's freedom excessively. Often this parent has a perfectionistic personality and may be vicariously seeking acclaim through the achievements of the child. The OP/OC parent will tend to produce a child who is a very "good" child, an actively compliant (AC) child, who is not oppositional. The problem with this "good" behavior of the child is that the child doesn't attend to its own needs and puts its parents' needs first. This child tends to develop stomachaches, headaches, and other psychosomatic symptoms. The remedy for this child is for the parent to loosen up on control and focus more on the needs of the child, not the parent.

In the automatic pilot or "cruise control" state, children are left to make decisions as much as possible on their own, and parents retain veto power only in "essential," as opposed to "elective," areas of the child's life. Figure 5, Child Behavior Locus of Control, depicts the essential areas of child behavior which include considerations of health, safety, productivity, respect, and communication. The elective areas involve items like friends, hair, room decor, when and where to do homework, and bedtime.

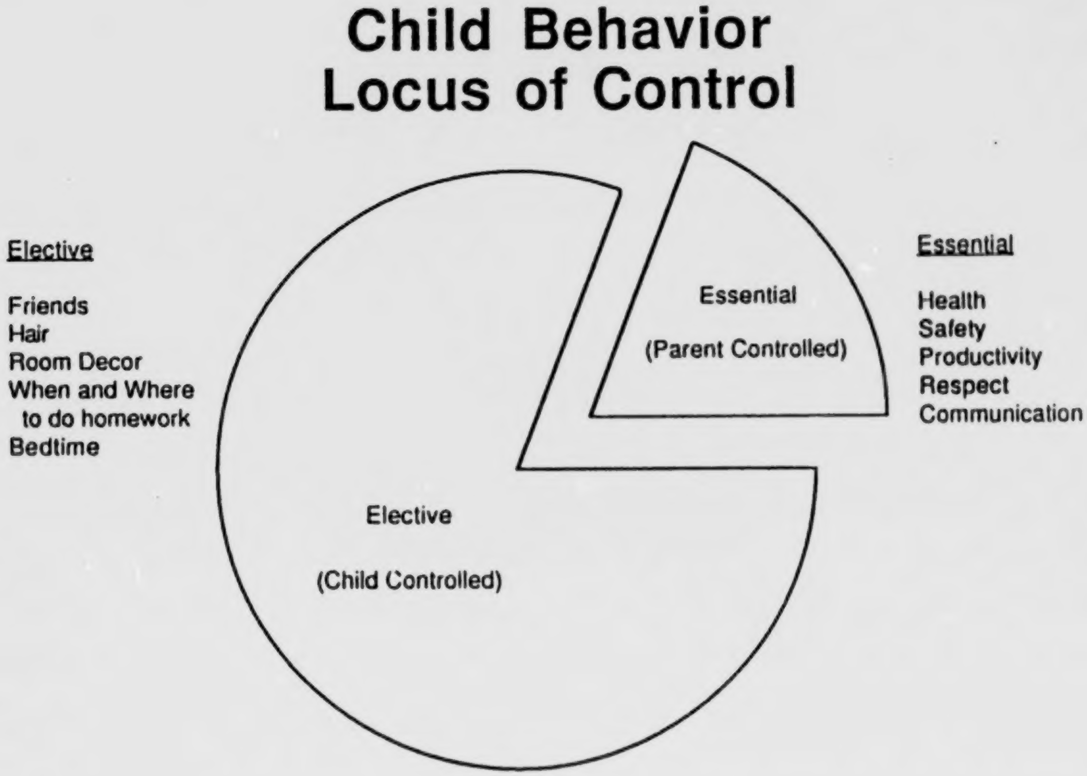


Figure 5: Child Behavior Locus of Control

3. The Underprotective/Overcontrolling (UP/OC) Parent

The underprotective, overcontrolling parent is again perfectionistic, but is so selfishly preoccupied that the child's nurturance is overlooked. This child does not feel loved, and may not be, and experiences the world as a very lonely and critical place to be. This child begins to "oppose" the wishes of its parents, but because of fear does so in a passive and indirect way to avoid censure. This child will begin to forget things, procrastinate, and have "accidents." This "passively oppositional" (PO) child will have to receive additional protection and less control to abandon its defensive and self-destructive habits.

4. The Underprotective/Undercontrolling (UP/UC) Parent

The underprotective, undercontrolling parent will let the child "get away with murder," but because the child feels unloved and underprotected, it generally chooses to "act in" instead of "act out." This child will withdraw, get depressed, and underachieve. This "passively compliant" (PC) child will need more protection and more control if it is to recover.

Adult Problems Underlying Child Problems

One of the premises of this book is that children are victims of family and school training deficits, as a result of which they develop their principal disability, M.D.D. By extending this process generationally backward into the past, it should also be clear that parents also suffer from M.D.D. symptoms, which are the result of the parent training deficits of their parents. To enable parents to become better parents, it is necessary to help them with their own adult problems, which now present themselves as individual adult psychological problems, such as anxiety and depression, marital problems, disagreements about parenting, and unresolved issues with their families of origin. Some parents respond to suggestions for change from relatives, friends, neighbors, or books. Others need to be prodded by an outside agent, an "agent provocateur." School personnel are in an ideal position to recommend changes in parent behavior necessary to help the parent's children.

Case Examples

The following case examples will hopefully demonstrate how intrapsychic thinking, family and school "job assignments," and parent, teacher, and caretaker disorders of protection and control sap children of the motivational energy necessary to behave themselves and to achieve.

Case #1

"Special" and "Sensitive"

Description of Problem

Consider the case of an 8-year-old boy named Gary. Gary had had several ear operations as a young child and had been living for his whole life with tubes in his ears. More operations were still being planned. In addition, Gary had been diagnosed dyslexic and learning disabled and was being "specially" educated with speech and language therapy, a structured classroom, and other "special" services. His parents had taken Gary to several "special"-ists, and they had been advised by all, as well as by their pediatrician, that Gary was a "special" and "sensitive" child and that because of his difficult life, they should, in effect, go easy on him and give him "special" treatment. Gary had three sisters, 5,10, and 16, all of whom were not specially treated and were doing essentially fine although with these children there were more normal developmental issues of separation and individuation that were not being dealt with properly because of the overfocus on Gary. Gary, who was specially treated, was acting up, distractible, underachieving, impolite at times, and generally difficult to manage, mostly at home. The parents had been advised by all the experts that because of Gary's many physical, neurological, and learning problems, they should expect a lifetime of behavioral problems with Gary. They were advised to be patient with the cross they had to bear.

Etiology and Maintenance of Problem

As can be seen from the description above, the problem with Gary is not in Gary, but in the thinking of the adults in Gary's life. The behavioral problems that Gary exhibits are attributed to Gary's physical and learning problems and are excused as necesary concomitants of those problems. Gary is seen as a helpless victim of those problems and as having a diminished ability to behave himself and to do his work as well as the other children in the family. The diagnosis for Gary's behavior problems is confused with his other diagnoses, and the result is a treatment plan that is incorrect and ineffective, i.e., to be patient. The correct diagnosis for Gary's behavior problems is Motivation Deficit Disorder, i.e., a lack of motivation to behave, which is easily treatable through parental request, instruction, and, if necessary, enforcement.

In the case of Gary, a switch from intrapsychic thinking (the problem is in Gary) to interactional thinking (the problem is in the adult caretaking style) would have prevented the development of Gary's behavioral and underachievement problems and/or solved them once they started. Our families and schools, unfortunately, are entrenched in intrapsychic thinking, and it will take much education to open people's minds.In addition to bad advice from "experts" and "special"-ists, Mom and Dad disagreed on how much to expect of Gary. This is a common characteristic of parents with "problem" children. In this case, Dad was more sympathetic to Gary who, as a male and as the youngest child, reminded him of his own need to be protected from the harsh realities of the world. This protection he (Dad) got from his wife.

Case #2

"Honey"

Description of Problem

A second example is the case of a 15-year-old boy named Jake. Jake, like Gary, had been "specially" treated all his life, including being force-fed for the first six years of life because of a medical problem. Jake had been given every possible educational and psychological test and service at school and every possible concession at home to make life easier for him. There had been some underachievement and learning disability with an older sister, but more was expected of her, and she was currently doing fine as a senior in high school Jake had a younger sister who was also doing fine. Jake, however, despite thousands of hours of special treatment over fifteen years, was failing 10th grade and doing worse than ever. Dad, who called Jake, "honey," had recently attempted to strangle him and had been reported to the Department of Children and Youth Services (DCYS) for child abuse investigation. Mom and Dad, as usual, disagreed on how tough to be on Jake. The parents' marriage, which is also frequently a factor in child problem development, was of questionable vitality. No interaction was noted between husband and wife during several interview and therapy sessions.

Etiology and Maintenance of Problem

As is clear from the above description, Jake's problem is again M.D.D. and is not in Jake, but in the thinking and behavior of adults. Jake is given excuses for his behavior, which is attributed to medical causes. The adults conspire, unconsciously or consciously, to avoid correct diagnosis because of personal, marital, or family/school conflicts. Jake, of course, is the big loser in this comprehensive charade.

Case #3

Methaphorical Rebellion

Description of Problem

The next, and final, example is the case of a 15-year-old sophomore boy, Carl, who acted out at home and was barely passing at school. He was also abusing drugs, and had recently impregnated a girl. As usual, Mom and Dad disagreed on the correct approach, with Dad being stricter and even brutal at times, and Mom protecting Carl from Dad. Mom was similarly treated by Dad and was fighting with Dad in a way similar to Carl's, in a bid for more freedom. Mom couldn't fight Dad directly, so she fought indirectly by withdrawal of affection and sex, and fighting with Dad over her son's treatment. Carl, meanwhile, felt supported by Mom, and continued his indirect fight with Dad through underachievement and other passive-aggressive strategies. Carl's sisters, 14 and 11, were also showing symptoms of behavior disorder and underachievement.

Etiology and Maintenance of Problem

Again with this family, we see the familiar pattern: parental disagreement on parenting, and marital problems. School efforts to solve Carl's problems had been ineffective. At last bulletin, Carl was considering whether or not to move out of his house - for the third time. Mom had recently discovered a six-month affair that Dad had been conducting out of town.

Summary

The American child of the 1990s is increasingly "at risk" of contracting a wide variety of destructive "diseases." Intrapsychic thinking and the disorders of control by adults have created a crisis situation. Examples of child problems, their etiology and maintenance, have been provided in the hope of stimulating a switch in thinking from the intrapsychic mode to the interactional. Many other examples could be given involving all varieties of problems, mild to severe. Adherence to our current policy of either blaming or excusing the child, and ignoring those who trained him will only perpetuate the present crisis in child misbehavior, underachievement, and unhappiness.

The school, with its multiplicity of personnel, is in an ideal position both to observe the child dysfunction and to approach parents supportive with sometimes unpleasant information but, more importantly, with solutions. Unfortunately, at the present time, very few school officials envision or accept this role. This makes their own job harder and deprives children and parents of a crucial ingredient in their ability to change. What is needed is a collaborative format in which teachers and other school personnel approach, or are approached by, parents in honest and candid ways, and in which real individual or marital issues are discussed, including parenting disagreements, individual issues of anxiety and depression, marital conflicts, and family of origin problems. School problems need to be frankly admitted by school personnel, and joint strategies need to be devised to solve the problems without blaming the child. Adults need to be given change assignments, releasing the child to resume his childhood privileges and responsibilities. Only through an increase in collaboration between families and schools and through a change in adult thinking about children can we hope to affect the state of the child in the 1990's.

Chapter Three

The Collaborative Team Intervention (CTI): Orchestrating the Larger System

Within the FACETS model of child problem-solving, there is a progression of intervention steps or stages from simple procedures involving only the teacher and student to more complex ones. Step 6, the Collaborative Team Intervention, merits special attention because of its complexity and because, until a school coordinator is sufficiently trained, the meeting is principally conducted by the family therapist entering the school as a consultant.

General Considerations

The Collaborative Team Intervention is usually at least a moderately stressful experience for most participants because of several factors:

1. The scheduling of the meeting represents a failure of many previous attempts to solve a child problem; this is annoying, frustrating, and sometimes infuriating to various attendees at the meeting.

2. The meeting is an extra burden for teachers and other school staff, as well as for parents and others at the meeting. Although participants may care about a child, the meeting is still an inconvenience, sometimes a great one.

3. The interaction at the CTI is usually intense and involves discussions of topics not usually talked about in school, e.g., disagreements between parents, marital problems, school-family conflict, teacher attitudes toward students, and other matters. Personal issues of non-family participants at the meeting, e.g., teacher conflicts with their own

children, are often stimulated by CTI discussions. The forum atmosphere is a more honest and open one, and one which though eventually relaxing to most people, is initially stressful.

Preparation for the CTI

Because of the stress potential of CTIs and in order to maximize the honesty of the interactions, all participants should be briefed ahead of time about the kind of meeting it will be. Teachers especially should have some orientation to the program, and preferably in-service training in the overall FACETS model, including CTIs. Providing for this CTI training requires the leadership of the principal of the school and the central administration of the school district. Not all teachers will like the FACETS program, and the CTI may be the least liked aspect. Getting teachers to come to meetings with the proper attitude is sometimes a difficult task for a school leader, but it is an important task and should not be left to chance or avoided. Teachers who are unmotivated , angry, or negative at CTIs can have a destructive or delaying effect on the proceedings. "Bad" attitudes of teachers may, of course, be a small or large cause of a child's school problem in the first place, and the teacher's attitude is something that must be dealt with either during or after CTIs.

CTI Physical Setting

CTI sessions are usually held in the office of the school social worker, school psychologist, or other pupil services worker. Other classrooms or meeting rooms may be used. The CTI "players" usually sit around in chairs in an open circle without desks or tables to facilitate communication. The open physical format is designed to facilitate communication and to allow for movement between players to be orchestrated by the consultant. An example of such movement would be to move a teacher closer to a student to facilitate more direct intimate negotiations.

Interactions at the CTI

The nature or depth of interactions at CTIs is, of course, a key consideration. The general guideline is: do whatever is necessary to solve the child's problems. Discussions at CTIs will always involve adult issues, since as was stated in Chapter 2, adult problems underlie child problems. Parent disagreements with each other about parenting and other issues will be the most frequent adult issue addressed.

The way in which adult and other issues are addressed can vary. The issues can be brought up in the CTI with everyone present or can be dealt with as various people leave the session to resume their regular duties. Smaller subsections of the CTI can be arranged, and issues can be addressed privately, e.g., disagreements between a principal and a teacher regarding the teacher's attitude.

Flexibility of the CTI

The CTI does not derive its power directly from numbers and physical presence. What the bodies do at the meeting is what matters. The number of people at the CTI, the number of meetings these people attend, the length of time at the meetings, and other factors are all determined by their relation to the goal of child problem resolution. As an extreme example, even though a meeting of twenty people is scheduled, a school coordinator might cancel it if a mother walked in, admitted she was sexually abusing her child, and wanted a private conference with the school coordinator or principal.

Community Representation

Various community workers and personnel are invited to CTI meetings. Probation or youth officers are frequently invited to help in the motivation of those youths already implicated in illegal activity. Child protection workers may be invited when abuse charges have been filed against parents. Private therapists already working with a particular child or family can be invited. The goals of inviting personnel outside the family and school are several:

1. The coordination of work. It is often the case with children with school problems that several agencies and people are working separately or at cross-purposes.

2. An increase in leverage with a child or family. Each person at a CTI has a different relationship and type of influence with every other. Where one person, e.g., a principal, may not have much influence on a student, a court officer may.

3. An opportunity for everyone to learn from each other. The school and the systems therapist, e.g., hope to learn more about the workings of the larger system and also to influence its use of ecosystemic principles and procedures.

Fathers: The Missing Ingredient

Although everyone invited to CTIs is important, fathers may be the most important. In traditional interaction between home and school, fathers are often left out or involved as a vestigial appendage. Engaging fathers in child problem-solving enables school and other helpers to see up-close the often dysfunctional or strained dynamics in the marital relationship. It also enables helpers to more directly contribute to the healthy re-structuring of the relationship between parents, through their getting closer together or their getting further apart. Fathers may be a very destructive influence on their children or a very constructive one, but in either case, attendance at the CTI enables everyone present to understand the family dynamics better and to have power to affect the influence of the father in the family.

Scheduling of CTIs and Follow-up

The scheduling of the CTIs is the responsibility of the school coordinator. He or she knows the teachers' schedules and tries to make appointments during teachers' free-time, planning periods or sometimes before or after school. Follow-up is also the responsibility of the school coordinator and he or she must devise a customized method that works. Inducing teachers into co-responsibility for follow-up coordination is essential to the accomplishment of this task.

"Releasing" Interventions: CTI Strategies and Techniques

The next several pages provide a list of questions, statements, and actions that are designed to be used by the ecosystems consultant and the school coordiantor to move the CTI in the direction of quick and correct diagnosis of the child, family, and system problem, as well as the formulation of an effective and efficient solution. The strategies are provided in the order in which they might generally be used. Ecosystemic therapists may choose to use the interventions in a different order or to use only certain ones. The interventions are called "releasing" because they are intended to release participants from the stranglehold of the problem.

Intervention Techniques

The following items are intended for use by the school coordinator.

1. Start the meeting by introducing everyone. Introduce the ecosystems consultant as you would introduce everyone else, with an explanation something to the effect that the consultant is here "to help us with the problem we are having." The consultant will generally not have much to say until everyone else has spoken and interacted which may take as long as 30 minutes. Attempt to establish a positive, optimistic and respectful atmosphere by being pleasant, friendly, positive, and respectful with everyone in the room, e.g., shaking hands and greeting everyone. Participants in the session may be tense and defensive at first and perhaps looking to blame someone for the problem. The atmosphere should be businesslike, but relaxed.

2. Start the meeting by stating the purpose of the meeting, which is to solve a problem. Model from the outset the solution-oriented nature of the meeting. It should be clear to everyone that the leader is intent on arriving at correct problem diagnosis and clear recommendations for the solution to the problem.

3. After stating the purpose of the meeting, briefly summarize what has already transpired. Everyone at the meeting needs to be operating from approximately the same base of information.

4. Ask everyone for their opinions on the nature and cause of the problem and possible solutions. People like to be asked their opinions and thereby will be more motivated to work for a solution. In addition, the answer to the problem will more likely surface as everyone describes the sequence of interactions supporting the child's problems.

5. After everyone at the meeting has had a chance to speak and even interact briefly, introduce the ecosystems consultant again and ask for his or her opinion. As a school becomes more comfortable with the consultant, the consultant may break into the flow of conversation more spontaneously.

The following items are to be used by the school consultant and eventually by the school coordinator.

6. Reframe (or positively connote) any "bad" or reprehensible behavior of the child or anyone else as well-intentioned, to convey the notion that there are no bad kids or bad people. Suggest alternative positive motivations for bad child behavior, e.g., not wanting to disappoint Mom or Dad, or not wanting school and family to fight. Thinking of children as intrinsically bad or "bad seeds" is one of the major obstacles to finding solutions to their problems.

7. Look for metaphors in everyone's statements and behaviors, e.g., the eight-year-old girl's stubbornness as a reflection of Dad's stubbornness and negative attitude toward school as a youngster. Child problems are often metaphors for, expressions and mirrors of, adult problems, and the adult problems will need to be dealt with. Expand on the metaphors by asking if the child is the only stubborn (angry, sad, etc.) member of the family.

8. Ask parents to assess their level of agreement on the diagnosis and treatment of their child's problem. Probing will result in discovery of disagreement. Parents can then be asked which of the differing opinions the child should accept and how he should resolve his probable confusion.

9. Ask parents in the early stages of intervention: "How motivated are you to solve this

problem?" Stating a high level of motivation usually enhances parental involvement and openness to change.

10. Ask leading questions like, "Are there any other problems in the family we should be concerned about?" If parents resist going beyond the identified child, one can suggest that family problems are sometimes interconnected.

11. Ask parents, "Who is ______________ (the problem child) most like, Mom or Dad?" and process the ensuing discussion to establish the normalcy of the child's behavior in this particular family system and situation. This particular question usually elicits much smiling and other recognition responses from parents and leads to fruitful comparisons between parents and kids.

12. When family or school people are ganging up on the child negatively, ask everyone, "Is there anything good about ___________ (this child)?" This mildly "provocative" approach will usually stimulate positive statements about the child. Positive statements will then lead to more benevolent recommendations for overcontrolled and underprotected children.

13. When the child is being overly defended, say, "Well I'm not so sure there's really a problem here." This "restraining" technique will draw objections and lead to a more balanced appraisal of the child. The undercontrolled, overprotected child can thus be more clearly identified as a "brat" or "terrorist."

14. Ask the child what he or she thinks and particularly what the child would like to see happen. For example, ask the child what he or she would do at home and at school if he or she had Aladdin's Lamp and had three wishes, or what the child would do if he or she were in charge of home or school. These questions to children usually elicit much

interest from all present at collaborative meetings. Most children, even those previously morose or stubbornly non-communicative, may suddenly become animated and interested in contributing. Child responsiveness to these questions is strong evidence of the basic desire of children to self-regulate on "automatic pilot" or "cruise control."

15. If the child refuses to answer, do not insist that he or she talk, but "reframe" the resistive behavior as the child's attempt to "check out the scene," i.e., to hold back until he or she thinks everyone is serious about change. Giving children space and respect, at least initially, is sometimes crucial to engaging their eventual cooperation.

16. Ask the parents and school staff to talk to the child regarding the child's wishes. They should be helped to stay positive and to get honest opinions from the child, in short, to communicate well with the child. Parents and/or school staff who are close to the child usually have a better chance of communicating effectively with the child than the consultant/leader does.

17. Help parents and school staff to negotiate "deals" with the child and to get commitments from the child. Informal contracts, non-written preferably to convey trust and respect, can be set up. A monitoring system should also be set up. "Deals" are fun for everyone and tap into participants' gambling and general play instincts.

18. Siblings, who may have significant information to contribute, may be supportive of the "problem" child, or be "worse" than the problem child, allowing observers to move the focus away from the I.P. ("Identified Patient") and spread the problem around, "systemizing" the problem. Ask for their opinion. Because some siblings are so disruptive, it may be necessary to shift the entire focus of the meeting to another sibling.

19. Probe for transgenerational patterns and parental attitudes by asking parents what they were like as kids and how they were treated by their parents. Personal agendas are perhaps being acted out in their parenting. They can be asked, either directly or strategically, what they notice in their own behavior. Most parents, when asked about their past will be moved, perhaps even to tears, and will drop their defenses and be more honest about their parenting agendas.

20. Probe the marital relationship, asking whether both parents agree on various parenting, and perhaps other, issues. Parents can be asked to agree on a plan or have one parent go on "vacation" for a week. The good in both parents' behavior and approach should be discovered and noted. Most child problems are caused and maintained by parental conflict over parenting or other issues.

21. Probe the family-school relationship and, in case of conflict, pursue conflict resolution. Ask both parties who is right, and ask one of them to go on "vacation." Reframe both sides' behavior as good in some way. The family-school relationship can be identified as avoidant, competitive, merged, one-way, or collaborative.

22. Assess the motivational state of parents and school staff frequently during the CTI. Determine whether they are with you, or if you have to change course. Ask them frequently for opinions and recommendations or whether and when they are ready for an "answer" to their problems. Everyone's motivation for change can be enhanced with "distancing" and "restraining" statements like, "There are some excellent solutions to this problem, but I'm not sure they would be appropriate for this family (or school)." Make sure much frustration has been elicited by laborious recounting of previous unsuccessful treatments. Motivation for change may be high, but still secondary to motivation for staying the same. Recounting the history of frustration helps to increase parents' and others' active awareness of how much they need to change.

23. At some point in the session, give a diagnosis and suggestions for improvement. These comments should be given respectfully and framed as one person's opinion. An attempt should be made to reframe as much as possible, but the essence of the truth needs to be revealed. After a brief statement, the consultant should conclude his observations by asking what everyone thinks, especially the parents.

24. Give much time to clarifying and processing the consultant's statements. The goal is general consensus and a commitment from all present to follow a plan of action.

25. Intervene boldly in the session when necessary after securing everyone's agreement. For example, in extreme cases, ask parents to hold their child on the floor if the child is out of control in the session, or have them supervise time-out for the child outside the meeting room. The CTI is an excellent place to practice new approaches. The "bold" intervention is one of the main keys to collaborative success. Some therapists and educators beat around the bush for months or forever. The CIT is only 1 - 3 sessions and must proceed quickly and sometimes dramatically.

26. Use the "3-choices" technique: "You can stay the same, move to your left. or move to your right." Each problem situation will have only two choices besides staying the same. The leader can define the three choices and ask everyone to decide which he or she wants, as follows: "We can keep fighting with the child as we are now, get tougher on him, or get easier." The parents can be "positioned" into picking the best alternative. Caution: The two constructive child alternatives, e.g., being immediately respectful or moving out of the house, may be shocking to undercontrolling, overprotective parents.

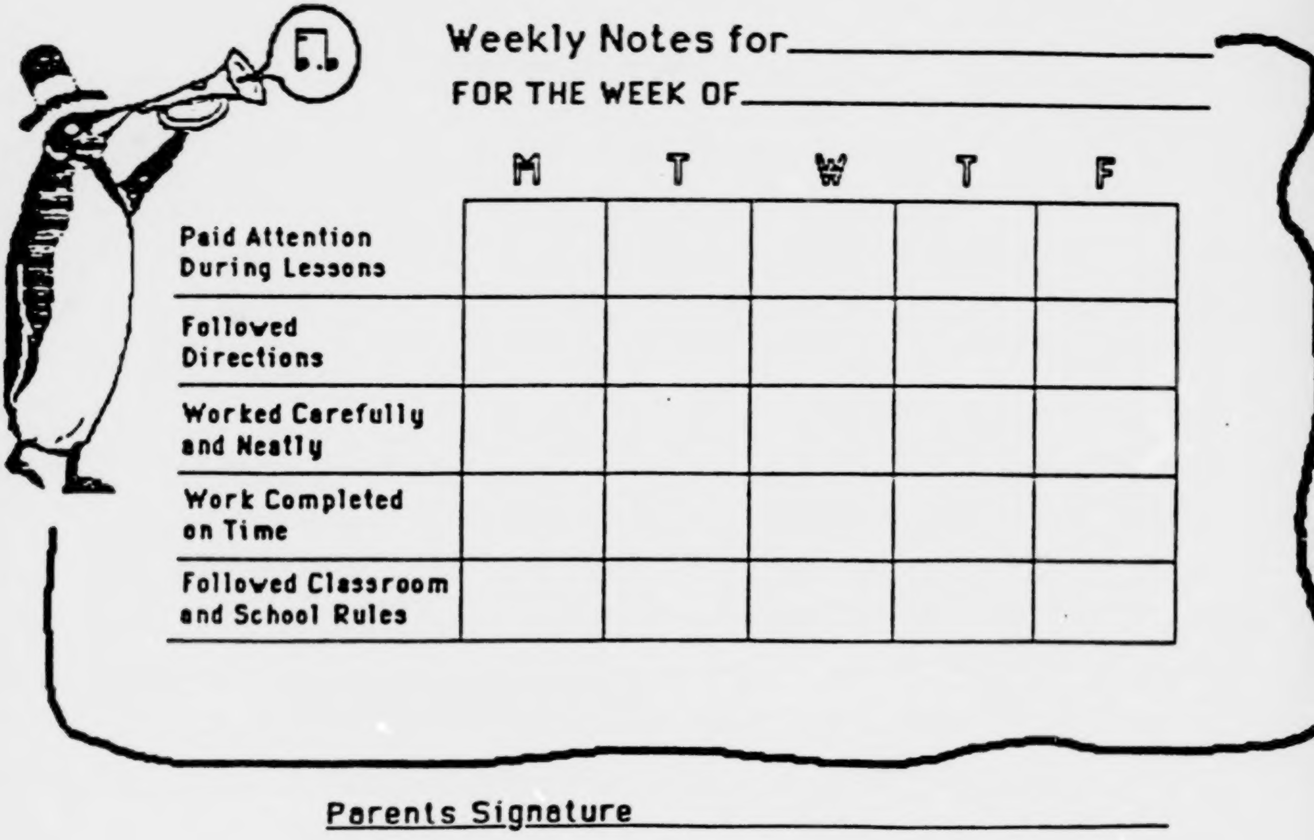
27. Arrange a classroom "circle" meeting for kids who are having problems with peers. The family of the problem child participates with the child and his classmates in a

positive discussion, including honest interaction about how to improve the child's social relationships. This method can be extremely effective and uplifting for all concerned.

28. Ask parents to advise the teacher what he or she could do with their child. New options occur to parents when asked in this way.

29. Implement a "daily report card" for kids who are not willing to cooperate with the teacher. The elementary school child might get a half-hour of free-time at home for each acceptable grade on a five-item card or list. Acceptable grades might be "smiley" faces, as opposed to "frowns." Unacceptable grades result in a similar amount of time on the bed with the rule of "no toys and no noise." This technique forces everyone to be reasonable and to increase interaction. Middle school and high school children might have a slightly different report card format with four grades or so for each subject. Grades (letters or numbers) are usually for classwork, homework, behavior, and effort. Each grade might carry a 15-minute positive or negative consequence. (Examples of daily report cards are given in Figures 6a and 6b.

DAILY REPORT CARD



Weekly Notes for____________________

FOR THE WEEK OF____________________

	M	T	W	T	F
Paid Attention During Lessons					
Followed Directions					
Worked Carefully and Neatly					
Work Completed on Time					
Followed Classroom and School Rules					

Parents Signature ____________________

Figure 6a: The Daily Report Card - Elementary School

DAILY REPORT CARD

Name ____________________________

HomeRoom ________________________

Day of the Week ___________________

Classwork and Homework

A - Superior
B - Commendable
C - Average
D - Passing
U - Unsatisfactory

Effort

1 - Above Average
2 - Average
3 - Unsatisfactory

Conduct

1 - Commendable
2 - Satisfactory
3 - Unsatisfactory

Subject	Classwork	Homework	Conduct	Effort
Reading				
Language Arts				
Mathematics				
Science				
Social Studies				
Phys. Ed.				
Unified Arts				

Comments

____
Mother's Signature

____
Father's Signature

Parent's Comments:

Figure 6b: The Daily Report Card - Middle School/High School

30. Arrange a "neighborhood meeting" in school or in the neighborhood to work out problems a child may be having in school and in the neighborhood. Parents and siblings of all relevant children can be invited, as well as relevant school personnel. The collaborative model aims to eventually change entire communities.

31. "Prescribe" some problems for continuation when the family is not "ready" for change, or because it may be "best." This "restraining" technique usually results in oppositional behavior from the child in the hoped-for direction. A child or family might be told that the child is not ready to be age 5 or 8, and that he should continue being 2 or 3 until he is ready. Unpleasant "regrettable" consequences of staying 2, like having to wear diapers or having to go to bed early, should be mentioned in a subordinate clause. Children and families usually rebel against these "restraining" techniques.

32. Provide "ordeals" for families in which people are not willing to change. Parents who are oversolicitous or overprotective of a child may be asked to come to school every day to make sure the child is "all right." Parents eventually will want to be relieved of this burden by having a more responsible child. A child's temper tantrums at home or school may be taped, and he or she may be required to listen to these tapes at inconvenient times.

33. Use humor, an approach underlying all the others. Humor merits special mention, because it can at times be the single, most effective, ingredient in the recipe for family-school collaborative success. Adults and children locked in the grip of intractable problems may need some humor to help them see the light. It also helps to camouflage or buffer the hard-hitting impact of the diagnosing of incorrect adult beliefs and practices.

34. Invite teachers into the home, e.g., to help an elective mute talk. Teachers can get

a fresh perspective, and parents may develop a new respect and openness because of this generous gesture.

35. Ask high school kids to convince parents to leave them alone and that they will take care of life by themselves. Getting kids to fight for themselves is often more effective than therapists trying to convince parents.

36. Invite friends of problem kids into the room. They will sometimes be more understanding of the child and parents and be able to articulate a more balanced perspective. This usually livens up the session and leads to child insistence on acting his age.

37. Invoke "percentage analysis" to get families to become clearer on their attitudes. A suggestion may be made, e.g., that since parents think school is 75% fair, the child should be 75% behaved. Using this type of analysis, for parents to get better than "C" performance from their child, they would need to find a way to perceive school expectations as more reasonable. This change of perception might then bring parents and teachers closer together.

38. Ask Mom and Dad to reverse roles, the "tough" one becoming "easy" and vice-versa. This request usually elicits laughter and is quite productive.

39. Bring in other participants from outside the family or school, e.g., police or probation officers, who may provide an added aura of threat or support needed for unruly kids.

40. Invite step-parents and other extended family members to the session to support the efforts of biological parents. Step-parents and other relatives or caretakers may be

utilized, and even be present, in collaborative sessions, but children usually respond best to biologically based directives.

Summary

The above general considerations, "releasing" interventions, and guidelines have been provided to assist ecosystemic consultants and others to lead collaborative interventions. Spreading the skill from consultant to school staff is an integral component of the overall collaborative plan. Use of techniques is not, however, a substitute for in-depth family therapy training, and those attempting collaborative interventions should do so only under the supervision of a trained family ecosystems therapist. In addition, whatever techniques are used, the main goal is the correct diagnosis of the child's problem, the identification of an effective treatment plan, and most importantly, the engagement of parents and other particiipants in a clear and stable commitment to success.

Chapter Four

Case Studies: Preschool

The following chapter contains several case studies of collaborative intervention with pre-school children and their families.

Case #1

The Boy Who Got What He Wanted

The first pre-school case involves Cory, age 3 1/2. Cory is what might be called a "brat" or "terrorist." He is the kind of child who has been trained to do whatever he wants, when he wants. Cory, not surprisingly, was driving everyone nuts. He had been referred to a pre-school special education program for learning and behavior management assistance. When the pre-school became frustrated after much unproductive effort, they requested "collaborative" intervention.

Seven people attended meeting #1 - Mom, Dad, Cory, his 1 1/2 year-old sister, the pre-school teacher, the pre-school psychologist, and the school consultant. It was almost instantly clear that, as is frequently the case, the younger daughter was more of a behavior problem than Cory. We started with Cory, however, since he was the parents' primary concern. One of the first steps in any collaborative intervention is always to have everyone recount all the efforts previously made to solve the child's problem. This gets everyone exhausted and more willing to entertain solutions which, besides working, will often be initially shocking to the parents' values or ways of living. In the case of Cory, Mom had been in parent counseling groups and had read just about everything written on child management. She had also solicited advice from many people, including her pediatrician. The result of all her research was that, because of all the conflicting advice, she was now thoroughly confused. Dad was typically peripheral, and left parenting to Mom, except when she did something effective, at which time he intervened to get her to ease up on the children. Dad had been allowed to do whatever he wanted as a child and wanted to continue the family "tradition."

Intervention

After an appropriate amount of recounting of the litany of previous effort, it was suggested that the parents "take charge" and "run the show." Mom was desperate and willing to listen to any approach that had a chance of success. Dad said he was open but, as we would see, he sabotaged Mom's efforts every step of the way.

When kids between one and ten or so are out of control and when they will not negotiate in any way with parents, it is sometimes most helpful to launch a frontal assault and insist on compliance. We are, of course, assuming that parent expectations are reasonable, which they often are. When they're not, we recommend increased parental flexibility. In the case of Cory, however, we had a bona fide "brat," and we recommended one of our favorite approaches, time-out on his bed when Cory wouldn't behave, backed up by "holding" him flat on his back on the floor until such time as he would go to his room as asked. This "holding," "restraining," or "exorcism" approach often works very fast and eliminates all the "child abuse" that is usually used instead - yelling, lecturing, hitting, threatening, grounding for years, etc. The holding procedure involves putting the child gently on his back, holding his wrists down, and sitting gently back on his thighs to keep him still. The child is allowed to get up when he or she agrees to go to the bed as asked.

In the case of Cory, Mom and Dad practiced holding him on the floor during session 1. Cory had not been willing to sit in his chair and discuss his behavior with us.

Dad did his best to sabotage his wife's efforts by talking to Cory frequently when he had been clearly advised to wait Cory out. In addition, when he was on top of Cory, Dad let him squirm and move, and was "amazed at how strong Cory was" - all of which conveyed to Cory that Dad did not expect compliance. Fortunately, Mom, who had to live with Cory all day, did like her new sense of control and gradually prevailed on her husband to at least stay out of her way.

Results

Even after session 3 of collaborative intervention, both children were still not totally appropriate. Cory was much better, however, and the younger daughter was gradually getting the message. Dad's interference clearly delayed success. Mom, however, was thrilled to know what to do when her kids were ravaging her house. School behavior, which had not been as big a problem, was also improved. Everyone involved was quite pleased after 3 sessions of collaborative intervention. Mom subsequently attended a few sessions of a "Parenting For Success" workshop conducted by the school consultant and attended a follow-up videotaped group interview in which she spoke favorably about the intervention. She also agreed to speak to other parents of "terrorists-in-training" whom school staff had asked her to advise.

Discussion

The case of Cory is not unusual. Dozens of pre-school children who have been out-of-control have been helped in similar ways. Holding and concomitant work with parental expectations works virtually every time when parent requests are reasonable and when parents and step parents are united and cooperative with each other. Work with parents can be done in an office setting, but the assistance of the school staff and the use of the school setting are often crucial in getting the parents to agree to intervention and in getting them to persevere to successful outcome.

Case #2

The Boy Who Had No Future

Background

John was severely neurologicaly damaged since birth. He was now age 4 and completely unmanageable. He looked strange, with eyes seemingly going in different directions. He wandered around aimlessly, muttering haphazardly. He was almost totally unresponsive to verbal direction. His parents felt sorry for him, and thought he had no future whatsoever. The mother was depressed, and envisioned a life of slavery to a demanding, uncontrollable person. The father withdrew from the problem. Both parents concentrated their hopes and efforts on a younger, normal daughter, age 2. Parents and professionals alike felt quite helpless with John, and thought he might be incurably schizophrenic or autistic, in addition to severely brain damaged.

Intervention

John, his sister, and his parents were invited to a meeting at a town pre-school for children with special needs. The meeting was attended by the school psychologist, other school support staff, e.g., the speech and language specialist, and the systems consultant. After listening to everyone's comments and judgments while John wandered around the room aimlessly, the consultant gave his interactional analysis. Although the consultant recognized that John was obviously afflicted in many individual and biological ways, he believed that the parents and other adults were contributing to the problem by expecting little from John. He believed that asking John to behave in normal ways and, if necessary, physically forcing him to do so, would result in improvements in behavior, attentiveness, and responsiveness. Such expected behaviors would be sitting in a chair, looking at Mom and the teacher when they were speaking to him, etc. The consultant recommended physically shaping John's behavior, and pinning him on the floor when he refused to cooperate. John's parents were reluctant to employ this procedure. Mom was afraid of traumatizing John, and Dad thought it would be a waste of time. They did, however, agree to try.

Two weeks later, the parents reported no success. Upon examination, it became clear that they had given the procedures very little attention. With the help of the other team members, the consultant discussed John's strengths and potential. School personnel were able to report positive behaviors of John not observed at home by the parents, mainly because they were not looking. A second and third week of experimentation were agreed to by the parents.

Results

After the parents began to work seriously on the treatment plan, they began to see results. They were in touch daily by phone or in person with school staff. John began to comply and pay attention. Though he continued to look different from kids because of his neurological problems, the differences were progressively reduced. The mother confronted her husband on his underinvolved position, and he became a more active father. Both parents became more hopeful about John's future. Three and a half years later, John continued to improve, and his parents were very pleased with how far he had come.

Discussion

Most situations in life, no matter how dismal, can be improved. Chidren's problems are generally mainly the result of parenting behavior. For parents who care about their children, a change in level of control is the principal vehicle of success. In John's case, an increase in control was necessary.

The collaborative format, based in school, was also essential to the outcome of the intervention. Without the daily school program for John and the daily interaction between the parents and the school staff, there would have been little chance of success with John.

Case #3

The Girl Who Wouldn't Visit Her Mother

Michelle, age 4, would not visit her mother. She said she was scared, that Mom didn't treat her well. She lived with her grandmother who also had temporary custody of Michelle's sister, age 7. The mother had lost custody of her children because of drug and alcohol abuse, violent behavior toward the children, and a generally irresponsible lifestyle. Michelle's sister did visit her mother on every other weekend and seemed comfortable with her. This daughter was also a behavior problem in school, though somewhat less so. Michelle was a severe behavior problem at a town pre-school she attended. The grandmother worked as a teacher's aide for special children at the elementary school attended by the older daughter. The grandmother was living with her second husband.

Intervention

A collaborative meeting was scheduled at the elementary school of the older daughter. The meeting was attended by Michelle, her sister, the grandparents, Michelle's teacher, the director of the pre-school, Michelle's sister's teacher, the school psychologist, the principal, and the systems consultant. Because of the severe friction between the grandmother and the mother, and between the mother and the biological father, who were divorced from each other, it was decided not to invite either biological parent to the first meeting.

After hearing the reports from various parties and after questioning and observing Michelle, the consultant recommended increased control tactics for Michelle. She had been disruptive in the school session, and did meet the "brat" criteria. Grandma and her husband did admit allowing disrespect from Michelle at home, partially motivated by feeling sorry for her, and agreed to tighten up their management. School officials were advised to use time out at school, and the consultant visited the pre-school to help them implement the procedure. It was also decided to invite Mom and Dad to Session Two.

Michelle's mother failed to show up at session 2, but her father did. The entire extended family had been in Court only hours earlier where the mother was petitioning for restored custody. The father revealed himself to be concerned about his children and cooperative, but rather passive and aimless, and likely to return to his old irresponsible ways. The pre-school, the elementary school, and the grandparents were making some headway with Michelle and her sister. Another meeting at school was held, and six months later, five private office sessions, three of which were attended by Michelle's mother.

Results

The collaborative and private work with Michelle and her family were not completely successful. Michelle's mother revealed herself to be a self-serving, narcissistic, and revengeful person. She dropped out of therapy as soon as it was clear that she would be expected to change.

There were, however, several positive results. Michelle was helped to stand up to her mother in the safe environs of various group meetings and her level of anxiety decreased. Teachers at both schools became aware of the nature of their students' "interactional" problems, and became equipped theoretically and practically to teach and otherwise help them. Grandma and her husband became better parent managers, and received support and advice on how to deal with Michelle's mother. Collaborative support continued to be available to all parties.

Discussion

Although Michelle's mother continued her oppositional and unreasonable behavior, at least in the short run, other positive gains occured. The collaborative format put a number of interactions in motion which had short-term benefits and the potential for continuing positive ramifications. Once a school gets involved with families, it continues to be a support and resource in countless ways for years to come.

Case #4

The Boy Who Couldn't Speak

Background

Doug, 5, could not speak, i.e., use words intelligibly. The problem had been diagnosed as primarily neurological. He attended a pre-school for children with special needs. His parents were referred by a friend to the private practice of the school systems consultant because of marital problems. The husband had been having an affair. In five private sessions, Doug's parents worked on their marital problems, and the husband claimed that he would give up his girlfriend. When Doug's neurological problems were introduced as an issue, the therapist suggested a collaborative meeting at Doug's pre-school.

Intervention

The first meeting was attended by Doug, his sister, age 3, his parents, the school psychologist, the speech and language teacher, and the systems consultant. The school staff did know about the parents' marital problems, but this was not the focus of the session. After listening to comments and making observations, the consultant noted that in addition to neurological problems, Doug seemed to have abilities of cooperating and paying attention that he was not using. The speech and language therapist concurred that some of Doug's behavior seemed to be primarily oppositional, not neurological. The consultant recommended increased parental expectations for Doug and the use of physical force and negative consequences, like lying on his bed in response to failure to comply. Although the parents felt sorry for Doug and worried about potential traumatizing effects, they agreed to try the procedure.

After two weeks of intermittent use of the procedures, the mother was convinced they were helpful. The father was much less cooperative, and admitted that he was embarrassed about Doug's inadequacies. He felt unfairly burdened and withdrew from Doug whom he viewed as the source of his anger and disappointment. Disagreement over the procedures was added to the list of parenting disagreements. The father was eventually discovered to be continuing his affair, and his wife asked him to leave the house. In addition to two school collaboration sessions, Doug's mother attended 17 private office sessions with the school consultant, mostly alone, and 13 group sessions with other women experiencing adult relationship difficulties. Doug's father did leave the house.

Results

Doug's parents ultimately were divorced. Doug's mother struggled emotionally and psychologically to cope with feelings of rejection, loss, and low self-esteem. Her ex-husband was quite uncooperative in many ways, including inconsistency in implementing the management plan for Doug's oppositional behavior. With the help of private therapy, special education for Doug, and the personal support of Doug's mother by the school staff, mother and child made progressive and significant gains. The mother became increasingly confident in parenting and in dealing with her ex-husband. Doug began to behave better and to speak more often and more clearly. Within six months, he began to speak in sentences.

Discussion

The private and collaborative help offered to Doug and his family were ultimately very successful. The results were bittersweet, because a marriage ended and a child had to endure the significant absence of his father at least temporarily. Doug did, however, begin to speak, which thrilled both parents. As Doug became more "normal," the father became less embarrassed and repelled by him, and began to be more nurturing. Eventually, a changed, but more healthy family structure enabled Doug to make faster progress in coping with his developmental problems. Collaboration between therapist and school personnel significantly enhanced this process.

Summary

Pre-school children exhibit many problems that parents, teachers, and other adults find challenging. These problems may be neurological, developmental, or behavioral, or a combination of these and other factors. Modification in parental and other caretaker use of control and protection behavior is the key to the solution to child behavioral problems. School-based collaboration intervention at the pre-school level enables parents and teachers to intercept child problems early and to formulate an adult caretaking style that will maximize healthy psychological development in the child.

Chapter Five

Case Studies: Elementary School

The following case studies are taken from school-based collaborative interventions with elementary school students and their families.

Case #5

I Can See The Ball Again

The Case of Jeremy

Jeremy, an 11-year-old boy in the fifth grade, had been diagnosed as Learning Disabled and Hyperactive with Attention Deficit Disorder at age six and had already been retained once. As a labeled special education child, he had spent part of every day of his first five school years in the elementary school "learning center." In addition, he had been taking Ritalin (7.5 mg O.D.) for four years and more recently Dexedrin for one year on the advice of a pediatric neurologist whom the parents and school personnel thought of as an "expert." The parents had switched from Ritalin to Dexedrine after four years because of what Mom called "attitude problems resulting from Ritalin." Jeremy had also been provided with summer tutoring by the learning center teacher, individual in-school counseling by the school psychologist, and language therapy by the speech therapist who, in addition to language work, initiated a behavior modification program for poor social behavior. The learning center teacher had had literally hundreds of consultations with the mother over the years, and Mom had herself seen two or three psychiatrists individually. They all prescribed various anti-depressant medications for her. While the idea of marriage counseling had been discussed in the mother's therapy, few marital sessions had taken place, supposedly because her husband was resistive.

After all these attempts at helping young Jeremy over five years, and literally thousands of hours of informal efforts by home and school, one would expect to see at least some small improvements. Unfortunately, if anything, Jeremy was unimproved or worse.

What follows is the school's description of what is called their "presenting concerns" on the referral form used by the collaboration program.

- poor social behavior
- difficulty maintaining friendships
- negativistic and antagonistic attitude towards peers (long-standing problem since grade 2.)
- resistance to school work
- easily frustrated
- distractible
- producing minimal work in learning center
- appears to be angry with teachers
- talks, shouts back
- makes statements like, "You don't have time for me"/"You didn't teach me that yet."
- apathetic mood
- low self esteem
- desires to spend more time in regular grade 5 classroom
- dislikes language therapy.

After making no progress with Jeremy at the beginning of now his sixth year at the elementary school, the school decided to refer Jeremy and his family to the school-based collaboration program that had been on-going in the school district for two and a half years.

Intervention

The first collaborative team meeting with Jeremy and his family was attended by ten people - Jeremy, his father and mother, his regular teacher,, his learning center teacher and language teacher, the school psychologist (who set up the meeting), the school nurse, the school principal, and the school consultant. Jeremy's ninth-grade sister was out-of-town and could not attend the session. The meeting began with everyone describing the problem, which was stated in much the same way as provided on the referral form. There were now several differences, however:

1. Jeremy was present to listen to everyone discuss him together. This format conveys respect for the child's ability to handle information about him sometimes withheld from so-called "handicapped" children.

2. Jeremy was asked what he thought and to interact with staff members and parents regarding diagnosis and solution. Thus, there was an expectation of involvement and an attitude of respect conveyed to him.

3. All present could hear everyone else's opinions at the same time and interact. In this collaborative environment, new and different information about Jeremy had a greater chance of surfacing than from one-to-one or smaller group interactions. Also, information given only to some could become public knowledge for everyone to hear. By the sheer number and importance of the people present, and

by the narration of the sad story of adult ineffectiveness and student failure, a strong need developed to solve the problem fast. It was possible for individuals one at a time to deny the problem, get discouraged, and procrastinate, but with everyone present, an extreme pressure was generated on participants to finally help the child. If nothing else, failure was embarrassing.

4. Through the introduction of a competent systems consultant, group interactions were skillfully orchestrated and new ideas and strategies were introduced.

Results

The following actions were taken during Collaborative Team Intervention with Jeremy.

1. The use of Dexedrine was discontinued.
2. Jeremy was allowed to earn more time in the regular classroom.
3. Jeremy was defined as "unhandicapped, "just as good as his smart sister." This re-definition was crucial not only for Jeremy but for everyone else present.
4. Jeremy was asked to help develop and approve the plan for his success.
5. Jeremy was asked to stop his temper tantrums immediately, conveying a belief in his ability to control himself. Unpleasant consequences were provided for the continuation of the tantrums, mainly having to spend "boring" time flat on his bed.
6. A "circle" meeting was arranged. It was attended by Jeremy, his

family, school staff, and Jeremy's regular class to discuss his social problems and solutions to them.

As a result of school-based collaboration, the ground work was laid for further, more intimate, interaction among all participants following the meeting, particularly between the parents and the school consultant and school personnel, for whom the parents now had greater respect and trust. In this case, the mother called the school consultant to discuss personal and marital problems, which resulted in the setting up of a private marital therapy session.

Results

In the case of Jeremy, the results were good. Jeremy did discontinue the use of Dexedrine, and felt much better. He said he could "see the ball" again, and did hit a grand-slam home-run soon after stopping the use of the medication. Dad, especially, was happy, since he never liked the idea, or the slightly immobilizing effect, of medication. Jeremy's "circle" meeting was extremely successful, leading to better relations with his peers, more control for Jeremy, and his willingness to come to the teacher in case of conflict. Jeremy continued to show problems in staying on task, but there were signs of improvement, and because of his behavioral improvement, the school staff was more hopeful that academic progress would gradually become faster.

Mom and Dad began marital therapy with the school consultant. Mom continued individual therapy with the psychiatrist, but went less often, and and eventually dis-continued individual therapy and the use of her anti-depressant medication. Dad gradually began to moderate his view that his wife was the main, or the only, problem, and to put more effort into pleasing her. Mom began to moderate her demandingness and to give her husband "the benefit of the doubt." The parents were both extremely pleased with Jeremy's behavior, and Dad began to help him every night with his reading. The school staff was extremely pleased with the intervention because for the first time in five years they felt in control of the problem and confident they were making progress.

Discussion

Reframing "neurological" child problems as motivational allows problems not primarily neurological to be solved. Most child problems are of this variety. The school is an ideal site for the initiation and implementation of this reframing process.

Case #6

Many Facets

Background

The presenting problem children in this case study were four children of three adult siblings all of whom had serious personal and marital problems and shared the parenting of their children with their own parents, the grandparents. All of the children in all three families, a total of six children, lived with the grandparents. Two of the sibling/parents also lived in this home without their spouses from whom they were divorced. One sibling/parent was divorced and lived elsewhere. The interventions took place in three stages over four years.

The first intervention concerned Kevin, 6, and his sister, Betty, 8, who were both acting up in their school classrooms and at home. Mom was a recovering alcoholic and drug addict. Dad, from whom Mom was divorced, was in prison, but did still have some contact with his kids. Mom and her three children lived with Mom's mother and father, with Mom's brother, his two children, and Mom's sister's 17-year-old son, Cameron.

The second intervention was seven month's later and involved Cameron, who was also a behavior problem, but who was temporarily controlling himself at the time of the first intervention in order to graduate. After graduation, Cameron moved in with his mother and her second husband in another state, whereupon he began to deteriorate. He took showers infrequently, began using drugs again, and did nothing productive.

The third intervention occurred over four years later with Kyle, 6, the first of two children of the adult male sibling who also lived with his parents. This father had also been using drugs, but was at this time recovering. The children at this time lived alternately with their father and their mother who lived in another town. Kyle was a behavior problem at home and in an after school day care program, but not in a public school kindergarten. He had been the given the diagnosis of Attention Deficit Hyperactive Disorder with Hyperactivity (A.D.H.D.) and was prescribed Ritalin, the dosage of which had been recently increased. Kyle had regular sessions with his neurologist and a child advocate, both of whom the mother trusted greatly.

Intervention

The first collaboration session was attended by Kevin, his two sisters, his cousin (17-year-old Cameron), his grandmother and grandfather, his mother, his teacher, his sister's teacher, the school psychologist, the school social worker, and the school consultant. After listening to the various accounts, the consultant diagnosed Kevin's and Betty's problem as a motivational deficit disorder stemming from Mom's undercontrol. After securing everyone's agreement with the diagnosis, the consultant recommended practicing the use of control tactics immediately within the session. When Kevin refused to behave in response to his mother's direction, e.g., to stop interrupting and to sit still, Mom asked him to sit in a time-out chair away from the group.

Mom was guided through the use of the "holding" procedure in which Kevin was restrained on the floor on his back. Mom referred to the procedure as an "exorcism." Betty was also exposed to the procedure as practice. Mom and the grandparents were instructed to help each other out in enforcing rules at home. Two more sessions were held during this first stage of intervention.

Seven months after the three collaborative sessions with Kevin and his family, Kevin's Mom's sister initiated therapy for herself and her son, Cameron, who had come to live with her after graduation. During seven sessions, this mother was helped to negotiate solutions with Cameron for his problem of irresponsibility. Cameron's mother also worked on getting her own personal life in order, including taking a stand with a neglectful husband.

Four years later, two collaborative sessions were held with Kyle, age 6, at an elementary school different from the one attended by Kyle's cousin, Kevin. Kyle and his mother were accompanied by Kyle's grandmother and Kyle's child advocate. The meeting was also attended by Kyle's kindergarten teacher, the school principal, and the school consultant. After hearing everyone's opinion, the consultant diagnosed the problem as a motivational deficit disorder stemming from the undercontrol and overprotection of the mother. The consultant recommended discontinuing Ritalin, abandoning the neurologist's hypotheses as a primary explanation for Kyle's misbehavior and switching to greater reliance on child management approaches. Kyle's Dad attended the second collaboration session, which Mom did not attend.

Results

The multigenerational results of collaboration were excellent. Kevin and Betty responded immediately to the "exorcism" approach of their mother who was very pleased to learn an effective method of child management. Grandma stopped undercontrolling the grandchildren and undercontrolling her adult children. In private sessions, Cameron's mother learned how to take a stand with Cameron and how to deal more effectively with herself. In the third intervention, with Kyle, the third adult child/parent was able to find a more sensible control tactic than Ritalin. Unfortunately, this parent's ex-wife was too mesmerized by other neurological and advocacy experts to be able or willing to look in the mirror at her own issues. Kyle did improve, however, despite the use of Ritalin.

Discussion

School-based collaboration can provide entry into home situations which are very debilitating and pervasive and which may not find their way to private office settings. In the situation presented here, three adult children of the same parents were malfunctioning as individuals and were bequeathing their problems to the next generation. Finding help available in school enabled drug-abusing, divorced, and otherwise troubled adult children and their parents to call upon that help many times and in many ways. It is likely that the site of the service, namely, the school, and the team format, offer distinct advantages in the task of working with multi-problem, multi-generational families.

Case #7:

I Don't Want To Be A Handicapped Child

Marie was 10 and in 5th grade at the time of the first collaboration session. She had been underachieving, distractible, and a general pest for all of her elementary school career. The fifth grade teacher was regarded as an excellent motivator and had tried everything he knew to motivate Marie. In addition, he had called and met with the parents on several occasions and consulted with the school psychologist on the management of Marie. Complaints about Marie had also been made in the past by her private pre-school teacher.

Marie had two siblings - one older sister,15, a 10th grader, and one younger brother, 8, a 3rd grader. The older sister was reported to be achieving and behaving appropriately. The brother was perceived as normal by the parents, but revealed himself to be as much of a problem as Marie. Marie's parents were middle-class and high-achieving people. The father was a salesman and the mother was a housewife who spent a lot of time at the exercise club. The consultant had heard through the grapevine prior to the first session that the father had questioned one of the town school administrators about the advisability of participating in the Collaboration Program. The father had, in addition, called several acquaintances "around the country" in an attempt to get more information about it. As is often the case with parents of problem children, there was a great resistance to facing the problem, and a delay of several months before agreeing to meet. The first session was held in the first week of May, with only seven weeks left in the school year.

Intervention

The first collaborative session was attended by the whole family, i.e., the parents and their three children, the school psychologist, the 5th grade teacher, the school principal, and the systems consultant. The session began with the usual recounting by all present of the history of the problem and of individual preceptions and judgments regarding its cause and solution. The parents reported advice from various professionals and others attributing Marie's problems to laziness, hyperactivity, being "young for her age," and other causes. During this stage the disagreements among the session participants began to emerge. From the beginning of the session, the mother and father were observed to relate differently to Marie. Though they sat on either side of Marie in the circle, the father sat closer than the mother and appeared to be more protective of Marie, intercepting and interpreting remarks about her or to her. His arm was on the back of her chair. In response to direct questions, Marie talked in a somewhat disorganized fashion, in a voice that sounded like a much younger child, maybe 5. She talked nervously and alternated between smiling and looking confused.

Sensing the familiar disagreements between parents about parenting and the overprotectiveness of the father, the consultant chose to attack the problem by provoking Marie. He asked her what she thought about the situation and how capable she thought she was. She replied that she thought she could do better, but that she was lazy and that the work was becoming more difficult. The consultant noted that she had been having problems since pre-school. He asked her if she realized she was becoming a "handicapped" child and if she wanted to continue on this "road to being handicapped." At this point, the father angrily intervened and accused the consultant of cruel and unprofessional conduct. He increased his closeness to his daughter and she began to cry. The level of tension was great, and the father began to get up to leave. The consultant asked the father how frustrated he was with the problem and how much he wanted to solve it. The father agreed that things were serious and began to sit back down. The mother seemed more accepting and understanding of the consultant's provocation.

After everyone calmed down a bit, the consultant proceeded to give his analysis of the situation. He said he thought that Marie's problem was motivational, and that it was caused by the parents, particularly Dad's, protectiveness of Marie against the expectations of the "cruel" school. He said Mom's and Dad's attitudes no doubt came from their upbringing and perhaps other factors like their own relationship with each other. He said that the answer to the problem was for the parents to ask Marie to "shape up" and do her work, and to provide negative consequences, like time on the bed, if she didn't. He asked Marie what she thought of his ideas, e.g., if they were fair. Marie said she agreed with the consultant, and she meant it.

After some additional processing, the consultant suggested a 1- or 2-week experiment during which Marie would take home a daily report card containing grades on specific behaviors expected of her in school, e.g., paying attention and handing in homework. The grades were to result in home consequences, either positive (free time) or negative (time on the bed). Each of five grades was to have a one-hour consequence at home. All parties were advised to keep in touch with one another and to "sound the alarm" if the agreement was breaking down for any reason, e.g., if Dad was getting scared and was neglecting to impose consequences. Everyone agreed to the experiment, and a follow-up meeting was scheduled two weeks hence.

Results

The results of the one-session collaborative intervention with Marie were dramatic. Because Marie was upset at the meeting, her parents took her home after the meeting. On the way home, Marie told her parents she didn't want to be "handicapped" anymore. The next day in school, the teacher observed her to be what he called "completely different." The teacher characterized her behavior as "a 180 degree turnaround." She was polite, age appropriate, and productive. She was, in all respects, "a completely different child."

At the second and last collaboration meeting, the teacher reported the excellent results to the assembled group. The participants were the same. The "news" was not news to anyone except the consultant because everyone had been communicating with each other. The parents were, of course, delighted and reported significant changes in home behavior as well. Marie was more polite at home, more compliant, more cooperative with her siblings, and was even initiating work around the house.

Marie's teacher asked Marie to explain her "turnaround," and she was extremely articulate. In the session as well, she was a "completely different person." The change was truly inspiring. It was agreed by all that this would be our last session, but that we would keep in touch and reassemble if things began to deteriorate.

Discussion

Marie's underachievement, behavior problems, and general immaturity had been caused and maintained by parental overprotectiveness. Shifting the diagnosis from intrapsychic causes like hyperactivity to interactional causes was crucial to the solution of the problem. The school-based collaborative format increased the clarity and intensity of the school personnel feedback to the family and the likelihood that the parents would listen and act on the information. The systems consultant provided the expertise in interactional diagnosis and the courage and skill to confront issues in a manner that was direct and forceful, though respectful.

An additional benefit of the session was teacher training. As a result of one session of collaboration, Marie's teacher spontaneously took charge of conducting session two as if he were a veteran systems therapist. This he did well and with no formal training.

Interestingly a middle school follow-up with Marie and her family the following year revealed that Marie was still doing well, but that Marie's parents were separated and getting a divorce. As stated in Chapter 2, adult problems usually underlie child problems.

Case #8

6 X 3 = 18

Background

Linda, 8, a 3rd grader, had been experiencing mild difficulty reading since 1st grade. She was achieving at an average level in other subjects. Tests by the reading consultant, school psychologist, pediatrician, and opthamologist showed no structural or ability problems. In addition, Linda read voluminously, fast, and with excellent comprehension at home. Linda's parents were high-achievers themselves, very polite, and otherwise appropriate, and very concerned about their daughter's academic problems. Dad was an engineer and Mom was a housewife. Linda had one younger sister in kindergarten who was functioning well thus far. Linda had no behavior problems, and, though shy, did have friends. Linda wore glasses and was not as much of a "star" as her younger sister.

The school's response to Linda's problem had been to assign her to special in-school tutoring twice a week with a reading tutor. This plan had been in operation for two years and was in place at the time of the first collaboration session with the systems consultant, which took place at the end of May. Linda's time with the tutor had increased spontaneously during the past year because a change in the tutor's schedule allowed her to have more time available, which she chose to donate to Linda.

Linda's parents were increasingly frustrated, and had met with the school psychologist of the elementary school. The school psychologist had suggested many times to the parents that the problem was motivational, not neurological or educational, but the parents were not convinced.

Intervention

After a second year of meeting with Linda's parents, and after several months of resistance to meeting with the systems consultant, the first meeting was held. It was attended by the parents, the two daughters, the teacher, the school psychologist, the principal, and the reading tutor. Within minutes, the dynamics began to unfold. The teacher revealed that she was not overly concerned about Linda's performance, that it was after all average, and that Linda was experiencing some lesser difficulty with math as well. The teacher thought that Linda's achievement was acceptable, and that she might achieve at higher levels later in life as a result of developmental changes. The mother presented as a somewhat nervous person, overly protective of her older daughter. The father was less protective and concerned, it seemed, but still motivated to find a solution. Mom and Dad revealed that they were high achievers in school and wanted Linda to be well prepared for college. They also were concerned about her general level of happiness and adjustment. The special tutor spoke about and to Linda in a childlike voice no doubt designed to help Linda feel more comfortable but which, from the consultant's viewpoint, contributed to Linda's lack of motivation and responsibility. The tutor was mystified and concerned that despite hours of training in the task of multiplying 6 X 3, Linda could never remember the correct answer, i.e., 18. The consultant began to get the picture. The extra time with the tutor was really, in fact, reinforcing Linda's perceptions of herself as special, helpless, and incapable. It was revealed to the consultant after the session by the tutor that she (the tutor) thought Linda might be schizophrenic or psychotic.

The psychologist asked Linda what she thought about her ability and problem. She shrugged her shoulders and said she didn't know. The consultant presented his diagnosis, "Motivational Deficit Disorder," and attributed the problem to confusion and differing perceptions and expectations among the adults, as well as overprotective, "special" adult treatment of Linda. He did his best to show appreciation for everyone's efforts, but recommended that the adults shift their thinking from intrapsychic to interactional, and that they ask Linda to do her work, since all professional tests had indicated she was capable. In the interest of temporarily avoiding confrontation with the tutor, the consultant refrained from being totally honest and adding a recommendation to discontinue the use of special tutoring. This he did do at session 2, after the tutor had left. The school psychologist later processed this recommendation with the tutor in a manner that was intended to be helpful and instructive to the tutor. The consultant asked Linda what she thought of his ideas. She said she agreed. A 2-week system of home consequences for school behavior was instituted.

Results

The results of the intervention with Linda were impressive. She began gradually to pay more attention and to do more of her work. She acted and spoke more her age and quite maturely. In session 2, at one point in the session, the consultant spontaneously interrupted the adult conversation and said to Linda, "What's 6 X 3?" Linda instantly replied, "18," without a second's hesitation. The tutor, unfortunately, had left at this point, and missed the full impact of this vignette.

After some further discussion, the family and school participants decided that they were on the right track and would continue the current approach until some problem developed. The present book went to print prior to Linda's next school year, and follow-up on Linda is, therefore, not available at this time.

Discussion

The case of Linda is very common, unfortunately so. Intrapsychic thinking pervades our culture, schools, and families. A shift in thinking and practice can have dramatically positive results. It can also be controversial and cause trouble. In this case, the school psychologist had to confront the tutor privately to recommend a different approach. The tutor had been given similar advice before. She continued to be resistant and to hold to her way of thinking. As is discussed elsewhere in this book, school personnel and other professionals and leaders sometimes have strong commitments to the intrapsychic model, often because of unresolved personal issues in their own famiies. Intrapsychic thinking and practice from such important people wreaks extensive devastation on our interpersonal and cultural landscape. Great leadership (defined caring, vision, and courage), especially from school superintendents, principals, and other administrators, is required if children, families, and society are to be better served.

Case #9

First the Fire, Then Sweet Corn

Background

Peter, 9, in 4th grade, was underachieving in school. He was shy and withdrawn, and "forgot" to do his homework. Extensive efforts to help him learn apparently simple skills were only partially and inconsistently successful. There was much speculation about learning disabilities and poor IQ, though no test results thus far were conclusive. Peter had a younger sister, 5, who was behaving normally in school. Peter's parents were high achievers. Dad was a rather strict, no-nonsense type; Mom seemed a bit more accepting. Both were upset at the lack of progress of school and family efforts to improve Peter's performance.

Intervention

Peter, his parents and sister, Peter's teacher, his sister's teacher, the school psychologist, and the principal were assembled for the first collaboration session. After listening to everyone's explanation and after observing a very sheepish Peter, the systems consultant asked about the level of agreement between Mom and Dad on parenting. Mom smiled and discussed her disagreement with Dad's overly punitive style. Dad smiled, too, and mildly defended his approach on the basis of how he was raised and how frustrated he was with Peter's behavior. Both parents had already entertained the possibility that Peter's symptoms were purposeful, i.e., a retaliatory action against Dad's demanding and controlling behavior. Dad, though frustrated, indicated he was open to another approach.

The systems consultant proceeded to diagnose the child as overcontrolled and recommended a pulling back of parental control and more working with Peter in mutual problem-solving efforts. The consultant asked Peter whether he thought he had a problem and what he would like to do about it. Peter indicated that he thought he did have a problem and that he did not like Dad's punitive tactics. Peter's statements were made in a low voice, slowly and reluctantly. He seemed scared and angry. When asked about his feelings, he admitted he was angry at his father. The father, somewhat embarrassed and angry himself, was nevertheless willing to listen. He had heard similar criticism of his behavior from his wife for years.

It was decided at session 1 to try a 2-week experiment during which Peter would be in charge of his own work. No punishments would be applied for school behavior. Instead, Peter and his parents would monitor Peter's successes and difficulties and be available as consultants to Peter in his attempts to solve his problems. A daily report card was set up so that Peter and his parents would receive daily feedback on how Peter was doing. Although school success was defined as Peter's job, the daily report card was used to guard against the possibility of Peter doing nothing for two weeks, out of habit. Another safeguard was the subtle reference by the therapist to "other measures" that might be needed if Peter was unable to manage his own work.

Results

The results of the collaborative intervention with Peter were excellent. Peter began immediately to demonstrate more responsible behavior at school. He did more and higher quality homework, did bring home his report cards, and was observed by his teacher to be happier and more spontaneous. Peter was also more cooperative and happier at home.

A second and third session were held with this family during which some minor refinements in the operation of the plan were discussed, as were other disagreements between Mom and Dad. To allow for greater honesty among the adults, the children were sent back to class when the "adult" issues began to become the focus of the session.

Discussion

Peter's academic problems and "passive-aggressive" behavior were not primarily individual or intrapsychic, but interactional, caused and maintained by parental disagreements about parenting and other issues and by the father's overcontrolling style. A switch to interactional thinking and recommendations enaabled everyone to succeed in releasing Peter to do good work. As Peter began to show his ability, the family was also released to turn its attention to the undercontrolled "brat" behavior of the five-year old daughter and the marital issues of the parents. The family attended seven additional private office sessions with the systems therapist over the next 1 1/2 years to restabilize successful, but fragile, behavior patterns and to work through some marital and family of origin issues of the parents. A tribute to the helpfulness of the collaborative intervention was written by Peter's father. It was published in the quarterly PTA Council section of the town newspaper and is included at the end of this book as an articulate expression of the dynamics of one collaborative intervention. (See Appendix C) Through school and private sessions, Peter's father was able to better understand his own upbringing and to make conscious improvements in the ways he would be a father to his son.

Case #10

"I'm scared"

Background

Valerie, 7, a second grader, had been tired and distracted in class. Her teacher asked her how she was feeling and what might be affecting her. She was normally very alert and in good spirits. Valerie began to discuss the violent situation that been occuring at home. It soon became clear that her father had left home, but called and visited frequently and had arguments with his wife, Valerie's mother. There were three other children, a son, 13, in 7th grade, and two other daughters, 11 and 3. The 11-year-old was in 5th grade. After talking with Valerie, the teacher asked the help of the school social worker, who talked with the mother and, with her permission, arranged a collaborative session.

Intervention

The first collaboration session was attended by Valerie, her mother, her three siblings, Valerie's teacher, the district-wide school social worker, two guidance counselors from the middle school, one assigned to each of the two older children, and the systems consultant. The mother would not agree to the invitation of the allegedly violent father. Most of the talking was done by Valerie's mother, who seemed nervous but sincere and nurturing toward her kids. The oldest child, a boy, was quite withdrawn and depressed-looking and seemed quite affected by what apparently were critical verbal attacks from his father. Accounts were given of the father's violence, including lighting the mother's clothes and other belongings on fire on the front lawn. Alcohol use by the father may have been a factor in this incident.

After further discussion, the systems consultant recommended a meeting with the father, the mother, the social worker, Valerie's teacher, and himself to further explore the truth of the various allegations and to assess the possibilities for solution to the family problem. The father did attend the session and was, as the mother had predicted, very charming, but manipulative. He did not seem to trust anyone present at the meeting, and did not inspire trust. He did admit to some of the allegations of violence and did agree that the children were justifiably terrified. He claimed that he loved his children as much as the mother did, but that they were taking sides and not coming to see him enough. He did agree to improve his behavior and to assure the children of his willingness to change. A private office session was scheduled with the systems consultant to give the father a chance to present his case further and to give the consultant a chance to assess his credibility and, perhaps, motivate him further. After one office session with the father, the family did meet as a group in school for a third collaborative session.

Eight additional private sessions were held with the consultant over the next ten months with various members of the family. The main issue continued to be Dad's violence, and the children's ability to cope with it.

Results

The results of collaborative and private work with Valerie's family were mixed. The father never did totally renounce his violent behavior. He did moderate it somewhat, however, and the children became able to stand up to him. The father did not adequately provide for his family's financial needs, and the mother was forced to look for work. When it became clear that her income in the United States would be very limited, she chose to move her family back to the country from which she had emigrated several years previously. Both the mother's and father's families of origin were there, and the country was known for its liberal social benefits. No follow-up was yet available from overseas at the time of this printing.

Discussion

Collaborative efforts with families are not always uniformly successful. In the case of Valerie's family, a combination of school support of the mother and children, and assertive, but supportive, work with the father, enabled the family to cope with a very difficult situation. Schools continue to be faced with the task of working with large numbers of separated, divorced, and often antagonistic parents whose children are attending school. Each case is different and requires a flexible repertoire of support, confrontation, and negotiation. The collaborative model offers a format that is conducive to the enactment of this repertoire.

Summary

Elementary school children exhibit a wide range of behaviors troubling to adults. Most of these behaviors are not primarily neurologically, biologically, or medically caused. Approaching child problems from an interactional perspective and utilizing the school as the initial intervention site can often significantly enhance the likelihood of correct diagnosis and effective treatment of child home and school problems.

Chapter Six

Case Studies: Middle School

The following case studies are taken from school-based collaborative interventions with middle school children and their families.

Case #11

"Hanging From The Rafters"

Twelve-year-old Evan had been out-of-control for years. He had a younger brother, 9, who was also a behavior problem. His father, with whom he lived, had been divorced twice, and he had little contact with his mother, whom he missed. Evan and his brother were raised mainly by his grandmother who yelled and screamed a lot and then gave up. Evan had been found with weapons in school, left school when he wanted to, and was frequently found hanging from railings over deep stairwells in daredevil fashion. He was, of course, barely passing his courses.

Intervention

Collaborative intervention brought Mom, Dad, and Grandma together and put Mom and Dad, principally Dad, back in charge of Evan. A "daily report card" was designed which was Evan's responsibility to present to each teacher for daily grading and to bring home to Dad for home consequences. Dad's new fiancee became involved and was very helpful in keeping Dad on task.

Results

Under the new system designed through collaboration between home and school, Evan's behavior improved significantly. Dad assumed a new leadership role, and Evan responded. Teachers found new power through communication with Dad and put their efforts there instead of trying to solve the problems themselves. Evan eventually raised his academic level in school, to everyone's amazement, and was looking forward to doing well in high school. In high school, Evan's behavior deteriorated again. His high school did not subscribe to the methods of the collaborative model, and individual strategies like suspension were used. Evan eventually was placed in a residential treatment facility where, at least temporarily, his behavior improved.

Discussion

Even with extremely difficult situations, bringing the relevant parties together can make a difference. The difference will, of course, only be maintained if adults at home and at school continue to work together. In Evan's case, home-school collaboration did break down, and Evan's behavior became worse. Residential programs can work for a while but, eventually, the child must come home. It is the belief of this writer that school-based collaboration can offer many of the benefits of residential treatment without having to remove the child from a home and school environment to which he will eventually have to re-adjust. Because of a focus on change in the child, and not in the home and school environments, temporary residential successes with children are often short-lived.

Case #12

Sexual Abuse & Other Issues

Background

David, 13, was an underachiever and a behavior problem in 7th grade. He had been sexually abused at age 10 by his older brother, now age 17. The older brother had spent three years in various residential treatment programs and was now living back home and attending an alternative high school program in the local school district. David's mother, a single parent, felt sorry for David because of the sexual incidents, babied him somewhat because he was her last child, and felt overwhelmed by the task of parenting. When David was three, David's mother sent the older two of her three children to live with her ex-husband in another state. One of those children, the middle one, still lived there. David was recommended for collaborative intervention because of repeated incidents of disrespect and fighting in the middle school.

Intervention

The first session was attended by David, his mother, four of his teachers, the school social worker, the principal, the assistant principal, and the systems consultant. Various opinions and vignettes were reported. David was generally respectful but showed occasional signs of temper. The consultant diagnosed the problem as a motivational deficit disorder stemming from parental undercontrol. The sexual abuse issue was framed as secondary, though the presence of the brother who was generally irresponsible seemed to have many negative effects on the entire family. The consultant recommended stricter controls and negative consequences for David and his brother.

After a second session in school, David, his mother, and his brother began private office sessions with the school consultant. Twenty-seven private individual or family sessions have been held at the time of this account.

Results

Efforts to bring David's behavior under control were not immediately successful. He began acting even worse, in fact, leading to several suspensions and, eventually, referral to a special self-contained classroom for youth with special needs. He initially continued a similar pattern. Private therapy and school efforts were also focused on David's brother who, in the opinion of most people, had worse problems. Although he was no longer considered dangerous from the sexual abuse perspective, the older brother had become even more irresponsible in many ways since going to residential treatment. Although there may have been some positive benefits, he seemed less willing to work in school, at home, or at a job. He blamed everyone conceivable for his problems, and procrastinated terribly.

Although frustrated, the mother could not bring herself to ask David's brother to leave the house. An opportunity to make a change did arise when the older brother went to visit his father out-of-state. His mother asked him not to return. David's behavior, already responding somewhat to other procedures, did seem to be affected significantly by this departure. He made the honor roll in his special class, and became more respectful at school and at home. Plans began to be made for David's eventual return to regular classes in 8th grade.

Discussion

The solution to David's problem was multi-faceted. His mother needed consistent support and advice to help her with both children. She hadn't been able to manage the children when they were younger, and was now even more overwhelmed. Feedback and support from school personnel were essential for the mother, and collaborative disciplinary procedures gave a clear message to David. Collateral collaboration with the alternative school program helped the mother to realize that her older son was not going to do anything responsible voluntarily. This experience helped her to take a stand when her son left the state. Continued communication between the therapist and school personnel helped all parties coordinate their efforts on behalf of the children.

Case #13
The Victim

Background

Gerald, 12, was constantly being picked on. He was a big 7th grader, but had a whiney voice and "nerdish" behavior. He was naive and was an easy mark for pranksters. Teachers were becoming totally exasperated because of Gerald's complaints against other students which took up much of class time. Gerald would also occasionally retaliate physically and earn detentions or suspensions. He was underachieving as well. Gerald's parents were increasingly protective of Gerald and blamed the school for the problem. One teacher, in particular, seemed to be overly impatient with Gerald, and the parents had complained in writing to the school principal and superintendent of schools.

Intervention

A collaborative team meeting was held with Gerald, his parents, four of his teaachers, the school social worker, the principal, the assistant principal, and the systems consultant. The parents listened to school complaints but were, in turn, critical of the school. The consultant diagnosed the problem as primarily a motivational deficit disorder stemming from the disagreement between home and school about the seriousness of Gerald's victimization. Most probably, he stated, a combination of parental overprotectiveness and school underprotectiveness was the cause of the problem. The consultant recommended less protection by the parents and more protection by the school.

Following Session 1, Gerald did show more responsible behavior, e.g., paying more attention in class and complaining less. His problem behavior did not disappear, however, and three months later, Gerald's parents began private sessions with the school consultant. Five sessions were held over the next three months, and Gerald's behavior did improve dramatically in response to less protection and more control by parents. The increased negative consequences at home were the key variable in the equation. Gerald made the honor roll in the final academic quarter and earned consistently perfect grades on a customized daily report card. Gerald, his parents, and school officials were very pleased with the results. The parents wrote a complimentary letter to the school superintendent.

Discussion

Gerald's problem was rooted in adult behaviors, specifically inconsistencies between home and school treatment. Providing a format for negotiation and coordination between home and school released Gerald to go about the business of being a normal 7th grader.

Case #14

Who's in Charge Here?

Background

Carol, 13 and a 7th grader, moved into town only a few months ago, and was found to be losing weight rapidly. She had been 50 pounds overweight. When she dropped below her normal weight and showed no signs of willingness to change her eating habits, Carol was hospitalized in an eating disorders unit. Carol's mother was overweight. The Collaborative Intervention Team became involved as part of a larger collaboration between the regional childrens' hospital, a nurse monitor at a local hospital, and the family.

Prior to hospitalization, Carol had been performing acceptably in a special education classroom. She lived with her sister, a 5th grader, her mother, a single parent, and her mother's boyfriend. Carol's grandmother, her mother's mother, lived nearby, as did a couple of her mother's sisters. The grandmother was very involved in caring for her grandchildren, and supported her daughter financially and emotionally. The father was of unknown whereabouts.

Intervention

Following a hospital discharge planning meeting at the school attended by school staff, the mother, and a childrens' hospital representative, the first school collaborative meeting was held. Carol and her family had been referred by the hospital directly to the consultant's private practice, but because he worked with the school, he wanted to involve school personnel in the treatment plan. The meeting was attended by Carol, her sister, her mother, her grandmother, the special education teacher and other special area teachers, e.g., the art teacher, the principal, the assistant principal, the social worker, and the systems consultant. As the various participants reported their observations, a pattern of grandmaternal overinvolvement and three generational enmeshment began to become clear to the consultant. About 1/2 hour into the meeting, the consultant assisted the grandmother in moving her chair so that the mother was seated directly in-between Carol and her grandmother. Within a few minutes after sitting in this new location, the grandmother abruptly stood up and left the meeting in a huff. The social worker pursued her and was able to convince her to return to the meeting. When the grandmother left, the mother expressed annoyance at the consultant for precipitating the departure. Carol was especially upset at the consultant. When the grandmother returned, she refused to talk, but eventually agreed to talk with the consultant privately and at another time.

Carol's mother agreed to begin private office sessions with the consultant. She did attend fourteen private sessions with Carol. Carol's sister attended some sessions, and Carol's mother's boyfriend and her sister and brother attended one session each. The grandmother came in once by herself. One further school collaboration was also held. Telephone contact with the nurse weight monitor was maintained, and coordination with the school program was also maintained informally through the therapist's ongoing consultation at the school. In therapy, a pattern of love-hate relationship between the mother and grandmother became more clear. Mom would ambivalently criticize her mother terribly and a few minutes later defend her protectively. Mom was financially dependent on her mother and on her boyfriend and found various excuses for avoiding the task of supporting herself. She had been married twice already and seemed severely locked in permanent dependency.

The therapy focused on helping the mother to release her daughter from the middle of this triangle, and helping the daughter to feel less responsible for solving the adult problems. Carol also was spoiled by her grandmother and treated somewhat abusively by her mother at times. Therapy lasted 3 1/2 months. Mom reduced on her overcontrol of Carol and treated her with more respect. Carol began to understand the adult dynamics more clearly, and remove herself from the middle.

Although Carol's mother stopped attending sessions, not all problems were solved. The mother's boyfriend moved out, possibly in response to the family movement toward health, and the mother then moved back in with her mother. There was a school report that at the time of this printing, Carol and her family may have moved to another town. Follow-up information will become available in the next school year.

Discussion

Carol's eating disorder was one symptom of a severely dysfunctional three-generational and extended family pattern. In addition to individual and family treatment in the hospital, Carol needed ongoing family therapy and school support to individuate and separate from her family's enmeshment. Although all problems were not resolved, Carol did make significant gains in her ability to negotiate the family "mine fields." She did abandon her anorexic strategy and maintain her normal weight. She agreed to participate in a peer "teen esteem" group and began relating better to peers from whom she had withdrawn. Plans began to be made for moving her further into the "mainstream" educational program at school.

It is difficult to predict if, and for how long, Carol will be able to function normally. Her mother's and grandmother's attitudes and behavior may have been only marginally impacted. She did get significant help through the collaborative intervention, and in a school driven by a collaborative philosophy, deterioration in her behavior would most likely be picked up and worked with again.

Case #15

The Boy Without A Parent

Background

Jonathan, 12, was in 6th grade and underachieving. He already had been assigned to an in-school tutor for part of his school day, but was not doing the homework necessary to keep up with his class. Jonathan, alone with his single-parent father, had no contact with his mother. With the exception of a 1/2 hour after school with his father, during the father's break between his two jobs, Jonathan was alone all day after school. He put himself to bed. This pattern had existed for the past two years or so. Dad was invited into school for a collaborative meeting.

Intervention

The first collaborative meeting was attended by Jonathan and his father, all his teachers, including his in-school tutor, the school social worker, the guidance counselor, and the systems consultant. All the school personnel reported a similar perception - that Jonathan was very polite but seemed to have difficulty paying attention and doing his homework. Dad indicated a desire to be cooperative but was unable to do much more than he was already doing because of his need to work two jobs. He said that he had lectured Jonathan and even lost his temper with him, but nothing seemed to work. The father looked somewhat older than his age, had long hair tied back in a pony tail, and wore a dungaree jacket with peace insignias on it. It was the consultant's guess that Dad was a former drug user, a veteran of the 60's hippie drug culture, and a person suffering from low self-esteem and difficulty with impulse control. The father indicated that he was considering asking his mother to move in with him to assist in the supervision of Jonathan. The consultant diagnosed Jonathan's problem as a motivational deficit disorder stemming from undercontrol and underprotection and asked the father to attempt to provide more supervision. A daily report card was initiated, and Dad was asked to provide negative consequences on the weekend in response to any unsatisfactory performance by Jonathan. Satisfactory performance would be rewarded by praise, free time, and special time with Dad.

Four collaborative meetings were held with Jonathan and his father. Jonathan's pattern remained unchanged. It was strongly suspected by school personnel that the father, though agreeing to the collaboration plan, was not really implementing it. When pushed to clarify his home procedures, Dad became angry, said he refused to do anything different, and abruptly left the meeting. In a move unseen in several hundred other collaborative sessions, the father took his son with him, vowing to transfer him to another school. Jonathan did return to school the next day.

Results

Jonathan's father did not return for further meetings. The school social worker did try to "smooth his feathers" and maintain communication. The teachers, having witnessed the father's behavior, and having become more sympathetic to Jonathan's plight, began to work more positively with him. Jonathan's failure to comply was seen less as an intrapsychic "attitude" problem, and more as an interactional result of his circumstances. The in-school tutor, in particular, after consultation with the guidance counselor, social worker, and school consultant, began to develop a closer, more personal relationship with Jonathan and became a kind of surrogate mother. Dad continued to help Jonathan in his own way, since he did love him.

Through some combination of collaborative efforts, which are difficult to quantify, Jonathan improved his academic performance dramatically. Poor to failing grades in November were raised to Bs and As in June.

Discussion

Though Jonathan's father was unwilling or unable to fully or officially cooperate with school efforts, some combination of home and school interventions turned Jonathan around. Perhaps Jonathan simply turned himself around after seeing how much everybody cared or how helpless they were to help him. Most likely, the loving attention of the in-school tutor and other school personnel was a major factor. It seems likely, in this case, that without collaborative efforts in school on behalf of Jonathan, his pattern of underachievement and depression would have continued or deteriorated. Follow-up information will become available in the next school year.

Summary

The problems exhibited by middle school children are often of greater magnitude than those of younger age children. Middle school children are more likely to die or hurt themselves or others physically. The use of interactional thinking and school-based intervention is, therefore, even more crucial at the middle school level. It is hoped that the cases presented here illustrate the benefits available to children and families through the use of the school-based collaborative method.

Chapter Seven
Case Studies: High School

Case #16
The City Boy

Background

Mark, 15, an 8th grader referred to in Chapter 1 of this text, had arrived in town at the end of May, transfering to the local middle school from a city junior high school. Within one week of his arrival, Mark had developed some peer conflicts and had gotten into a physical fight. Since there was less than one month of school remaining, school officials had to decide how serious the problem was and whether it could, in a sense, "wait" until next year. After further discussions with Mark and his parents, it appeared that there was a substantial parent-child conflict between Mark and his mother, and between Mark and his father. Both Mark and his mother had been physically abused by the father from whom Mark's mother was now divorced. The family was referred for collaborative team intervention in the hope that the systems consultant might provide some prompt relief for the problem and, in addition, be available privately for follow-up with the family over the summer.

Intervention

The first collaborative session was attended by Mark, his brother and sister, age 9 and 6, his mother and stepfather, his father and his father's fiancee, all his major subject teachers, the school social worker, the school psychologist, the assistant principal, and the systems consultant. Through the various comments and interactions of the participants, it became clear that the mother had a short and explosive temper, and that the mother and Mark were still very angry at the father who lived an hour away. The father seemed to have made significant progress in the control of his temper. The consultant diagnosed Mark's behavior problem as primarily motivational, stemming from his parents' problems with temper, their continued anger with each other, and other parent dysfunctions. The parents were advised to stay calm, work out consistent home and school guidelines with input from Mark, and to work together on co-parenting Mark. The parents seemed receptive and agreed to follow the advice given. The suggestion was made by the school social worker that the family might call the consultant and see him privately if the problems continued.

Three weeks later, the mother and stepfather, the father and his fiancee, and Mark began private therapy focused on management of Mark's continuing unruly behavior. Eight sessions were held with the family over the next four months, with moderate progress. Mark's mother was called by the school because of teacher complaints about Mark's disrespectful behavior. A collaborative team intervention was held at the high school to coordinate home, school, and therapist efforts.

Thirty more sessions were held over the next eight months. In response to Mark's continued resistance to joint parenting and school efforts, he was eventually placed in a self-contained classroom in school and was sent to his father's when his mother couldn't control him. Communication between home, school, and therapy office remained frequent during the time of therapy . Mark was sent to his father's house for one to five days at a time, contingent upon his level of unmanageability at his mother's house. Mark's brother and sister also began to act up in similar ways, and collaborative interventions were initiated at the younger childrens' elementary school.

Results

Despite many ups and downs during the therapy process, Mark did gradually make progress, as did his brother and sister. He did become more respectful, and comply with "consequences" imposed by his parents for unacceptable behavior, i.e., lying on his bed or going to his father's . He became more respectful of teachers and was to be gradually phased back into the regular special education classes. Mark became closer to his father, and his mother became more calm and patient. The relationship between Mark's parents improved.

Discussion

Mark had been an abused child and was continuing to be abused. He was underprotected and overcontrolled and had developed a self-protective aggression which also served to express his frustration and anger. The principal mechanisms of change were his mother's adoption of a calmer parenting style, and Mark's reconciliation with his father. These outcomes were accomplished through family therapy and through a close collaboration between family, school, and therapist that was initiated by the school.

Case #17

"________ (Bleep) You."

Background

Jay was 14, a 9th grader, and quite uninterested in school academics. He spoke in a rather sarcastic, cynical tone. He seemed angry and sullen. Jay's father had a private business; his mother was a housewife and had a very active hobby raising horses. Jay's brother was 12, a 7th grader, who was also undermotivated at school, but much less severely. The parents had both had somewhat negative school experiences themselves and had had conflicts with prior teachers of Jay. School efforts to motivate

Jay were not succeeding, and he was referred to the collaboration program.

Intervention

The first collaboration meeting was attended by Jay, his brother, his parents, his special education teachers,the director of special education, an assistant principal, the school social worker, the younger brother's guidance counselor, and the school consultant. Upon hearing the parents talk and interact with Jason, it became clear to the consultant that Jason was angry at his parents and that the parents disagreed with each other about parenting and probably other matters. He also noted the similarity between Jason's cynical style and that of his parents. The consultant's diagnosis was motivational deficit disorder stemming from alternating overcontrol and undercontrol by his parents, contaminated by the mother's overprotectiveness in reaction to her husband's underprotective temper tantrums with the children. The prescription for change was a more nurturing approach to Jay by the father and the negotiation between Jay and his parents of an agreement regarding school behavior and performance. In three subsequent collaboration sessions and one private office session, the parental conflicts over parenting and general control issues were discussed. The father was a bit of an autocrat, and the mother dealt with him by withdrawing and retaliating indirectly.

No further contact occurred between family and consultant/therapist, nor between school and therapist for seven months. The acceptance of the collaboration model was tenuous at this particular high school, and the lack of school follow-up with the consultant was not surprising. One week before the end of the school year, the younger brother's name was brought up by a speech and language therapist in a casual conversation with the school social worker and consultant at the middle school. The consultant had been visiting the school on another consultation. It was discovered that the speech and language teacher was a good friend of Jay's mother, and that Jay and his brother were experiencing more trouble than ever. A collaboration session was convened at the middle school. High school officials declined to attend. It was learned at this meeting that Jay's parents had originally agreed with the consultant's suggestions several months ago, but that when Jay's behavior did not improve quickly enough at school, the school officials had referred Jay for psychological testing at a nearby city hospital. The parents reported being very unhappy with this process, and afterward demanding that their son be returned to regular mainstream classes. A state of severe conflict had ensued between the family and the high school.

Over the next four months, twelve family and marital therapy sessions were held at the therapist's private office, in addition to three collaboration sessions at the high school following Jay's entrance into 10th grade. Jay's and his brother's behavior were again a significant focus, but the principal work centered around the marital relationship.

Results

Jay's father was quite resistant to giving up his place as the "king of the castle," and was quietly furious about the increasing assertiveness of his wife. He refused to attend the last ten office and school sessions. Jay's behavior, and his brother's, did gradually improve. His mother learned to be less controlling with Jay and more controlling with her husband. The husband gradually got used to the "new and improved" family structure.

Discussion

Jay's and his brother's school behavior were a direct result of the modeling of the disrespectful and cynical behavior of their father, and the conflicts between the parents over parenting and other issues. The parents' school experiences had been somewhat negative, and they were in part acting out their own revenge against authority through their children. The primary mechanism of change seemed to be the mother's insistence on more respectful behavior by the father. School collaboration was a key ingredient in the therapy, both as the vehicle for the start of therapy and as a continuing component of the treatment plan.

It is important to note in this case that family therapy might have started 7 months earlier than it did and only occured rather serendipitously by a chance meeting with a school staff member who happened to be the mother's personal friend. Help for children cannot, of course, be expected to rely on such haphazard circumstances. For a collaboration program to work, there must be clear commitment to the use of the model and a strong resistance to abandoning its use in favor of less demanding and traditional intrapsychic procedures like psychological testing when family dynamics are the obvious cause. The "politics" of collaboration will be dealt with in Chapters 8 thru 10.

Case #18

The Boy Who Needed To Be Liked

Background

Mitchell was 16 and in 11th grade. He was a polite boy, the third of four children, but was unmotivated in school. In this, his junior year, he had now resorted to skipping classes and even skipping school. Mitchell's oldest brother, 20, was a good student in college. The next boy, 19, had dropped out of college. The younger sister, 12, was a good student in middle school. Mitchell's parents both worked out of the home. After many intrapsychic efforts to help Mitchell, the school referred him to the Collaboration Program.

Intervention

The first collaboration session was attended by Mitchell, his parents, several teachers, and an assistant principal. Mitchell was very polite, but non-committal and somewhat evasive. In the general interaction, the parents discussed their differences in parenting philosophy and style. Dad was somewhat overcontrolling and underprotective. He was visibly upset with Mitchell and critical of his behavior. The mother was more protective and seemed to be a bit annoyed at the father. The consultant diagnosed the problem as primarily a motivational deficit disorder stemming from Dad's overcontrol and Mom's overprotectiveness. He recommended greater communication between the parents and Mitchell and a negotiation on what negative consequences would be reasonable if Mitchell continued to violate school attendance rules. Mitchell was encouraged to speak up regarding any resentment he may have felt against Dad or any other problem he may be having. Three sessions were held in school. Mitchell's behavior was excellent during this time, and family therapy was not pursued further.

Two weeks later, Mitchell's attendance problems resurfaced, and the parents and Mitchell began family therapy. Thirty-six sessions were held over twenty-one months.

Results

Several rounds of apologies and fresh starts by Mitchell were experienced and processed. At one point, Mitchell ran away from home for three months of a summer. Dad's anger was a major obstacle to getting to the bottom of the problem. Mitchell was very attached to his Dad, felt terrible about disappointing him and his family, but was too intimidated, angry, or embarassed to be honest about his problem. After continued progress by Dad in his handling of Mitchell, the son finally began to be more honest about his real problem - a strong impulse to do whatever was necessary to earn the praise and affection of his friends. When friends would suggest he skip class, skip school, get drunk at parties, and do other "crazy" things, Mitchell would be unable to say no. When Dad learned how to be more understanding, less angry and less critical, Mitchell felt more accepted and began to open up about his problem. Mitchell was expelled from school before he eventually "woke up," but did re-enroll in an evening high school diploma course from which he eventually graduated. The school was not interested in further collaboration with the therapist prior to expulsion because the family therapy "was not working," and because they had other procedures that they were "required to follow."

Discussion

Children and youth have many problems that are difficult to talk about and that seriously disrupt their functioning. Open and nurturing parent-child relationships are the best inoculation and cure for these problems. When the family is malfunctioning, school attention is needed to observe problems and organize collaborative interventions. In the present case, the school was only partially committed to the collaborative model, and Mitchell may not have been helped at all if the family had not self-initiated the therapy. The school was not enthusiastic about further collaboration with the therapist and chose the intrapsychic pseudo-solution of expulsion as the treatment of choice for Mitchell. Collaborative commitment could have resulted in a more coordinated intervention that may have worked more quickly and kept Mitchell in school.

Case #19

The Depressed Teenager

Background

Henry was a 9th grader, 14, and a veteran of two placements in psychiatric residential treatment facilities in the past two years. During his recent stay, he was given anti-depressant medication and treated primarily intrapsychically. Henry's mother and father were divorced and were quite antagonistic toward one another. The mother was currently suing the father for more support. Henry had an older sister, 23, living out of the home, and a younger brother, a 7th grader, who was an underachiever and a behavior problem at the middle school. Since his return to school two weeks ago, Henry had already reverted back to his pattern of disrespect, skipping classes, and acting "weird." The high school and the mother were on the verge of placing him in a permanent residential facility, when school officials reluctantly agreed to a meeting with the systems consultant hired by the school district. The consultant had already worked with the present family in a collaborative intervention conducted at a middle school in the same school district.

Intervention

The first and only collaborative session was attended by Henry, his parents, all of his teachers, who stayed for ten-minute periods two or three at a time, the case worker from the Department of Children and Youth Services (DCYS), the high school social worker, a guidance counselor, and an assistant principal, the social worker from the middle school, and the school consultant. Throughout the discussion of Henry's problem, he sat with a baseball cap over his eyes looking downward in a mood that seemed to be a combination of morose, angry, and psychotic. Teachers gave accounts of Henry's behavior that revealed a positive and sane responsiveness to firm direction. The consultant already knew, from previous experience, that the mother was seriously overprotective, undercontrolling and, in general, ineffective as a parent. Her main interest seemed to be getting revenge against her ex-husband for leaving her. The husband was a recovering alcoholic, but a more balanced and effective parent. Unfortunately, he did not have custody of the children.

The consultant diagnosed Henry's problem as primarily a motivational deficit disorder stemming from his mother's ineffective parenting and the ongoing conflict between the parents. He prescribed negative home consequences for Henry's negative school behavior. He also prescribed a switch from the intrapsychic diagnostic approach and treatment plan currently in use at the high school and at the psychiatric center where Henry continued to go for individual therapy and increasing doses of medication. Continuing, he recommended the abandonment of the residential placement plan since Henry was not sick, but a "pain in the neck," and a return to school where the teachers' already effective work could be supported by home-school collaboration. Finally, the consultant recommended that Henry remove his cap which he had worn without censure throughout the one and a half hours of the meeting, despite a school rule against hats. The father instructed Henry to remove his cap, which he did instantly, showing clear respect for the father. The removed cap revealed a head half-shaven and half strewn with six-inch straggly hair. Finally, the meeting ended with everyone promising to think about the consultant's recommendations. Both parents indicated that they would call the consultant for private family therapy.

Results

What follows is a brief account which sheds some light on the strength of the intrapsychic foothold in schools, psychiatric facilites, and other institutions in American society and the obstacles in the way of the adoption of an ecosystemic collaborative model of child and family intervention. Within 24 hours after the high school collaboration session with Henry, Henry's mother reported the details of the meeting to Henry's residential facility psychiatrist. Outraged at the proceedings, the psychiatrist called the assistant principal to complain. The assistant principal, already opposed to the collaborative model, was only too happy to complain to the district director of pupil services and he, in turn, complained to the consultant. This latter director asked the consultant to call the irate psychiatrist and to try to address his complaints since, he said, "we have to work with these people." The consultant predicted total failure in his ability to communicate with the psychiatrist, but agreed to call. Upon identifying who was calling, after hearing of the consultant's wish to communicate on the matter of Henry and the school meeting, the psychiatrist proceeded to lace into the consultant, accusing him of being "the most unethical person he had ever heard of." He indicated that it was impossible to make a clinical judgment of a youth based on one session at a school and without extensive medical analysis and reports, that the boy was severely disturbed and depressed, and that he very much needed ongoing medication and individual therapy in order to develop a trusting relationship with the therapist. He angrily asked for the consultant's credentials and asked if the consultant knew the specifics of a lawsuit against a Washington, D.C., psychoanalyst who did not use medication on his patient during nine months of therapy. The threat underlying the detailed account was clear. The psychiatrist rebuffed any attempt of the consultant to discuss any matter, e.g., that the consultant was a family therapist and not a psychoanalyst, and eventually hung up. The mother continued "babying" the 9th grader. The intrapsychic school, home, and therapy plan continued, and the consultant was not invited back to the high school for the remaining six months of the year. Efforts by the father, the middle school social worker, the pupil services director, and the consultant to get the mother to think more interactionally and to face her underlying personal problems were unsuccessful.

Discussion

The problems encountered in the collaborative intervention on behalf of Henry are very familiar to the ecosystemic consultant. Of all the levels of the school system, the high school seems most attached to the intrapsychic model of diagnosis and treatment. To break through and impact the severe dysfunction in Henry's family, there must be a firm commitment of school leaders to the program. This leadership will involve taking politically charged positions against intrapsychically driven professionals, agencies, and institutions.

Case #20

"Leave Me Alone"

Background

Donna was 15, in 10th grade, and doing moderately well in school. She was, however, depressed and underachieving and spent many hours in the guidance office. Her stepmother was overcontrolling and intrusive. Donna's father was at work a lot, sympathized with Donna's position, but wouldn't fight a war with his second wife over the issue. Marital conflict was chronic and obvious, but neither partner knew how to face it. The stepmother had already raised children by a previous husband, thought she was an expert on parenting, and distracted from her marital dysfunction by bothering Donna,

Discussion

Individual, intrapsychic procedures for children and youth, while sometimes helpful, frequently postpone attention to the main issue, which is usually interactional. In this case, well-intentioned school officials skilled in intrapsychic approaches delayed the resolution of Donna's problems by reluctance to use the collaborative model. One two-hour collaborative session turned around a chronic family situation of long-standing. For schools to be effective with students, forceful, controversial procedures like a telephone debate with a reluctant father or diagnosing a marital problem in a school session will often be necessary.

Summary

High school students react to caretaking errors in even more extreme ways than younger children. Motivational deficit disorders now express themselves in drug abuse, suicidal ideation, and dropping out of school. Unfortunately, at a time in life when child problems are most severe, school staff are most likely to cling to the intrapsychic model because, they say, "It's too late to change family dynamics." Use of interactional thinking and school-based collaboration can be significantly more effective in keeping kids alive and in school.

Chapter Eight

Establishing and Implementing a Collaboration Program: Obstacles and Blueprints

The task of setting up a school-based collaboration program may be extremely frustrating. The task of keeping it going may be overwhelming. There are many obstacles, which might be experienced as "mines" in an educational "mine field," lying in the path of the systems therapists and school coordinators who become interested in establishing a school-based collaboration program for children. Some of the obstacles are as follows:

1. The first and foremost obstacle to the installation and operation of a school-based collaboration program is probably the educators' perception of the nature of their job as predominantly "academic." Although the original one-room school house setting may have promoted a closer, more intimate relationship between parents, today's teachers seem to withdraw from non-academic contact with students and their families. This distancing seems to increase as the child gets older. One of the contributing factors to this greater barrier is the introduction to schools of various support services like guidance, school psychology, social work, and special education. Whereas in the past, teachers may have had little choice in discussing non-academic issues with parents, now it has become the job of the "specialists." Although the arrival of the specialists in schools has overall provided an increase and wider variety of educational services, it has also resulted, in some instances, in a decrease in the level of regular teacher responsibility for the overall needs of the child, including the psychological or emotional needs. There are certainly many teachers who continue to take primary responsibility for the whole or holistic welfare of their students and to use "support services" in ways that were intended, i.e., as a "support." Others, however, withdraw from the holistic role. The philosophy and procedures of the collaboration model run full-face into what might be called this "partistic" approach to education that prevails in many schools.

2. A second and also very dominant obstacle to the collaborative model is, of course, the prevalence of intrapsychic thinking in schools, and in families, and in other institutions serving schools. When a child is not succeeding in school or is looking glum or agitated, many teachers will ask the child, "What's wrong?", and talk with the child about problem-solving strategies. When the "problem" reveals itself to be interactional, e.g., anger at or fear of parents, many teachers will decide that they are now "over their head" and refer the matter to the specialist or the administrator. Many teachers are uncomfortable discussing these matters with parents. Unfortunately, many specialists and administrators have also been trained primarily in an intrapsychic belief system and will primarily use the intrapsychic procedures of individual counseling, group counseling, peer counseling, and punitive measures. Contacts with parents usually stop short of communication about essential subjects, e.g., the level of agreement about parenting between parents and the level of peace and happiness in the home. Educators often think these matters are "none of their business," and yet they are the primary factors in the level of student performance and behavior in school. The success of the collaborative model depends upon the use of interactional thinking and behavior with students and families.

3. A third obstacle to the collaborative model is the level of insight produced in collaborative discussions and meetings and the similarity between the problems in the student's family and those in the teacher's family. Educators are human beings, too. Most are married or divorced and have children. Many educators have the same problems with their own children or their own marriages that are being discussed in the collaborative meetings. Often the parent-child conflicts that become clear in the meetings are similar to the teacher-child conflicts with the same child; or the teacher and parents(s) are taking opposite and antagonistic approaches to a child. The parallel or other relationship between a family problem of the student and a family problem of the educator is a matter that should not be overlooked by the prospective "collaborationist." Even principals, superintendents, and school board presidents are human beings and have family problems. The ability to establish and maintain a successful collaboration program requires a clear understanding of this connection and a readiness to deal with the often defensive, angry, and avoidant behavior of educators who sometimes instinctively withdraw at all levels from the intense personal emotionality generated by collaborative discussions and interventions.

4. A fourth obstacle to the collaborative model is a political one. Unfortunately, teachers and other educators are sometimes more interested in promotions, raises, power, comfort, public acclaim, and other matters than they are in the welfare of students. The effective use of the collaborative model usually requires increased effort or change on the part of educators and a willingness to do whatever is necessary for child success. The school officials who support the collaborative model will be taking a stand which may bring criticism and even rage reactions to their door or desk from parents, teachers, support staff, school board members, public agencies, private therapists, psychiatric facilities, and any number of other sources. The successful use of the collaboration model requires the presence of leadership qualities in the personalities of its proponents. Leadership might be defined as vision, caring, and courage. The leader must have all the qualities sought by the tin man, the scarecrow, and the lion from The Wizard of Oz. Successful work with students requires adults to "look in the mirror" to see in the students' problems the reflections of adult problems and the dynamics of adult mismanagement of children. This "look" is often upsetting to adults, and some are willing to avoid it all costs, even at the cost of losing children to suicide, car crashes, and drug overdose. Those interested in collaborative intervention will have to be prepared to encounter the powerful effects of the political motivations of educators and other people.

5. A fifth obstacle to the collaborative model is the lack of staff training and skill in interactional thinking and behavior. To play successful collaborative roles, staff must be asked to undergo significant in-service training which ideally would take as much as 10 or 20 hours. The skills and belief system demanded by the collaborative model are not learned overnight by most educators. Achieving staff compliance with the collaborative training requests again requires the availability of leadership qualities in school administrators. Most teachers eventually report very positive results from participation in the collaborative venture, but initially the change is difficult for many, and, for some, it is something they will oppose forever.

6. Money is a 6th obstacle to collaborative installation and operation. This obstacle is often a pseudo-issue presented spuriously by those opposed to the collaborative model. Sometimes it is a real issue, however, and the collaborationist will need to have some suggestions for sources of money or be able to motivate school administrators to redirect the use of current funds or find new sources. An argument can be made that utilization of the collaboration model can actually save money through briefer and more effective intervention and the subsequent reduction in the need for further and often more expensive services, e.g., residential placement of students out of the school district. Unfortunately, the obvious enormous financial advantage of prevention over rehabilitation does not seem to be enough to influence the policy-makers in education and government.

7. A seventh obstacle to the acceptance of the collaborative model is a collection of myths about collaboration that may be held by educators, and others involved in decision-making. These myths may include some of the following:

a. Parents won't open up in large school meetings
b. Fathers won't interrupt their busy schedules to come to school during their work hours
c. Parents will sue the school for defamation of character or payment for endless therapy for problems raised by school officials
d. Real "therapy" can't be done by educators

These and other myths are often believed by educators and become obstacles to the acceptance of the collaboration approach. To "demythologize" the model, collaborationists will need a variety of arguments or references.

8. A final set of obstacles to the acceptance of collaboration has to do with the personal characteristics of the therapist/consultant. Because of the number and intensity of obstacles to collaboration, its acceptance and success require in the therapist an extremely high level of energy, commitment, perseverance, patience, sensitivity, openness to criticism, genuineness, maturity, and therapeutic skill. The school system was referred to earlier as an educational "mine field." The active and goal-oriented collaborationist, if he or she is doing a good job, will frequently feel, and perhaps be, on the verge of rejection and expulsion from the system. The collaborative model is a kind of intrusive drug or surgical implant that is attacked by the immune system of the host organism, namely, the school, and only gradually accepted, if at all. The collaborationist must be ready for dismissal by some schools and expect the willingness of only a small percentage of schools to even consider, let alone begin, the use of the model.

Directives

The following guidelines or suggestions are presented as directives to those therapists interested in establishing collaboration programs in schools. Some of these directives may be obvious or optional, but all are offered as items in at least a partial list of recommendations:

1. Identify and contact a school staff person who is interested in the collaborative model. This person will generally be a school social worker, school psychologist or other support service worker. The contact may be initiated by the school worker who may have seen the consultant present the model at a conference. The contact person may very well eventually be the school coordinator of the program.

2. Meet with the "power structure" of a school building or district, i.e., the decision makers. These meetings could begin with even one decision-maker, e.g., a school principal, but should ultimately include various support staff and district-wide administrators like the pupil personnel or special education director. More than one meeting is normally be necessary. The meetings are usually arranged and mediated by the school contact person and are focused on a description of the model and discussion of its potential value to the educators. Obstacles to the implementation of the program are also covered. References can be offered from school coordinators in other collaboration sites.

3. Start a pilot program in one school. A "10 Most Wanted" list can be constructed for referral to the program. Strategy Meetings and Collaborative Team Interventions (Steps 5 and 6 of "The School Decision Chart") should be scheduled for the "most wanted" problem students who have been identified. The school contact person, who probably has now become the school coordinator, should take charge of inviting all the

relevant school, family, and community representatives. The cost of the therapist's/consultant's time needs to be negotiated here. Some free "demonstration" work may need to be offered. The school faculty should be informed about the initiation of the pilot project. The ecosystems consultant should be introduced to the school staff by the principal, and a brief overall presentation on the program should be made to the assembled school staff by a team composed of the principal, the district-wide pupil services director, the school coordinator, and the school consultant. Opportunity should be given for questions and some expression of annoyance which will likely be observable. Staff should be told that they will have ample opportunities for training in the collaboration model, and that their active participation is highly encouraged. It should be stressed that the use of the model will probably result in better student morale and performance in their classrooms.

4. Conduct Strategy Meetings and 1-3 session Collaborative Team Interventions (CTIs) for the identified students and families. One new series of interventions should begin each week. Time should be made available to school staff before and after CTI meetings or at other times to process any questions, objections, or comments they may have. The school coordinator should be in charge of maintaining contact with school staff and should act as a liaison between all parties.

5. Schedule in-service training for teachers. As mentioned earlier, interactional thinking and behavior are not necessarily natural for educators or easy to accept and learn. While much learning takes place in CTI meetings, formal instruction, role-play, and informal candid clinical discussion are also important. A weekly clinical case conference in which collaboration cases are discussed is one training format. A sample of a more formalized training format for all school staff is provided in the CEU Training Format found in Appendix D. The use of in-service training can be the difference in the success or failure of a collaborative program.

7. Maintain close and ongoing communication with the school decision- makers. No matter how successful the program, there probably will be "nay-sayers" who for various legitimate and other reasons, are looking for ways to "bad-mouth" the program. Maintaining a good relationship with school leaders is essential to the consultant's successful passage through the "mine fields."

Summary

There are many obstacles to the acceptance and continued success of collaborative efforts in schools. To gain acceptance by schools and to "survive," collaborationists must have more than excellent therapeutic skills. They must have unusual personal qualities of endurance and must have the strong support of school officials who are real leaders. Attention to the "mine-fields" in schools and use of the directives given here will hopefully provide prospective collaborationists with a map and a set of instructions that will be helpful to their mission.

Chapter 9
Beyond the Child and Family: Impact on Schools and Communities

This book has been about solutions to child problems and, more importantly, solutions to underlying family problems. Perhaps even more important than these considerations is the effect of the collaboration approach on school personnel and climate, and on the community.

Impact on the School

Unfortunately, as mentioned earlier, family-school relationship patterns tend to fall into one of the four dysfunctional categories - avoidant, competitive, merged, or one-way. With the introduction of family-school collaboration, things begin to change.

1. In the first collaborative session with the first child referred to the program, teachers begin to hear things about the family they have often not heard before, e.g., that the child's father was just like him at this age, or that Mom and Dad disagree vehemently about how the child should behave.

2. Teachers often report being rattled and uncomfortable in these situations, but they can't leave and are forced to hear things they would tend not to ask about and would generally avoid if they began to surface in one-to-one interactions with parents.

3. Teachers are also supported by the presence of several school personnel, often including an administrator, who help to make the situation more manageable.

4. Someone outside the school, or someone internal to the school, e.g., the school psychologist, is conducting the meeting. The teacher can concentrate on giving information and leave the confrontation or negotiation with parents primarily to the consultant. Teachers who have been ill-trained in dealing intimately with parents can learn at close range, in a customized, personal way, how to do it.

5. Teachers can watch parent-child interactions orchestrated by the consultant and consider the similarities and differences in their own interactions with the children. A child's behavior, heretofore mysterious and/or infuriating, can become much more understandable and appreciated when seen in an interaction with parental behavior.

6. Because of the intimacy established in the collaborative session, teachers and school personnel begin to see the pain and desperation parents are experiencing and can henceforth relate to them on a different level. Interpersonal barriers are often totally or significantly discarded by both parents and school personnel under the pressure of group efforts to solve the child's problem. Few child problems can continue in the context of this intimate, honest relating between intelligent, caring adults.

7. The collaborative session results in a team plan for child success. Because of this, school personnel begin to make solving the child's problem a top priority. Procrastination, discouragement, and other attitudes lose their power to interfere with success. School personnel begin to treat other child problems in the same way and to believe that all child problems can be solved instead of "lived with."

8. Teacher - teacher and other school staff interactions begin to take on a

different flavor. Formal interactions, e.g., child study or PPT meetings, become solution-oriented. Informal interactions begin to be more positive and full of child success stories, instead of weather, gossip, or complaints about this or that "impossible" child.

9. Interdisciplinary staff interactions tend to become more intimate, and the barriers begin to drop between administrators and teachers, and between regular teachers and special teachers. Personal revelations by school staff to parents are now public knowledge for use by school staff with each other. School climate can be very positively affected through more intimate interactions among school staff.

10. School staff can apply to their own lives some of the ideas and techniques learned in collaborative sessions. Better parenting or marriages can result, as well as better coping with individual psychological or professional educational issues, like teaching or administrative style. Teachers may initiate personal therapy following collaborative sessions.

The impact of family-school collaboration on school climate is one of its greatest benefit. School personnel have great impact on children, second only to parents. Adoption of the collaborative philosophy leads to a commitment by a school to solve all significant child problems - NOW.

Impact on the Community

With the onset of collaborative work in schools, the community itself begins to change.

1. Parents talk to other parents about systems, metaphors, and families of origin. Child problems are increasingly seen by all as symptoms of adult and societal problems.

2. Adults hearing about collaboration begin to blame kids less and take more responsibility for leading the way.

3. Parents not involved in collaboration begin to approach the school more assertively and with the hope of more constructive interaction with school staff. They are are willing to be honest about personal, private matters.

4. Parents are less likely to label kids and send kids to special education, rehabilitation centers, and hospitals. Changing a child's home life is seen as a better alternative.

5. "Special" programs begin to focus more attention on changing family life instead of ignoring parents, writing them off and taking kids away from them.

6. Taxpayers and boards of education begin to realize that it is a lot cheaper to pay for a few collaboration sessions than to send a child to a special school for years, sometimes as much as $100,000 cheaper for one child.

7. Private medical doctors and therapists begin to revise their diagnoses and treatments from individually-based to systems-based, and to be more attentive to the need to communicate with schools.

8. The notion of privacy or confidentiality is radically revised since everyone now is part of the problem and no one else needs to have information.

9. Medications are used less, as their uselessness or destructive side-effects becomes more obvious.

10. Children take more responsibility for self, are happy, commit less crime, grow up straight, and create a better world for all of us.

Summary

Although the "collaborative approach is principally focused on changing children, the institutions involved in collaboration also begin to change. It is in the wake of large-scale institutional change that child problems can be most efficiently avoided or solved.

Chapter Ten

The Future of School-Based Collaboration: In the End, A Question of Leadership

The collaborative movement has just begun. Although the first article describing the collaborative method (Aponte, 1976) was published fifteen years ago, and although hundreds of articles have been published since, collaboration is still considered a pilot project. The rather slow-motioned acceptance of the collaborative concept is a testimony to general societal resistance to any change, but also perhaps to a special resistance of school systems and of family systems to the controversial nature of the collaboration concept. Both of these factors combine to provide a great wall of resistance or a "black hole" absorption of multiple efforts to make an impact.

But it is the thesis of this book that collaboration is an idea whose time has come. Previous chapters have covered how to establish a program and how to conduct collaboration sessions. In this chapter, some steps are outlined that must be taken if family-school collaboration is to move from the level of pilot project to that of prioritized standard practice.

Future Steps

1. The care and feeding of the collaborative "gorilla." The family-school collaborative specialist must be treated as a prized "gorilla" (Kami, 1989) and as a product champion (Drucker, 1967). The collaborative specialist brings a controversial and sometimes abrasive message to families and schools. He or she is going to provoke, antagonize and confront incorrect and destructive belief systems. The superintendents of schools, principals, and other school leaders must be induced into showing support of the collaborative gorilla and into demonstrating their willingness to protect him or her

against the forces of "the dark side," e.g., professional complainers, jealous rivals, ignorant people, and vested interests. The collaborative specialist will tend to be loved or hated, and the school administration must be prepared to stand and fight, rather than to run scared at the first assault from either the well-meaning or the ill-intentioned. The gorilla will find it hard to live in a habitat in which his every grunt and gesture are questioned, and he must have select bananas.

2. Coming out of the closet. A related concept to support of the gorilla is that of coming out of the closet. For family-school collaboration to have its maximum effect on a school system and a community, it has to become popular, well-known, and publicly accepted. For this to happen, the school superintendent, building administrators, PTA leaders, and other influential people have to be willing to come out of the closet and admit that such a program does indeed exist. In one school system where collaborative work is supported, the high school PTSO (Parent-Teacher-Student Organization) did not know of the program three years after it had started. Similarly, at the elementary school where the program was most active for four years, the president of the PTO had never heard of it.

There are "turf" and "threat" factors ("TnT") in schools which block its acceptance. The program tends to be treated as "classified," and those wanting to establish a collaborative climate in a school or school district will need to fight for its acceptance. After a very successful first-year collaboration pilot project in one school, the first request for "collaborative" intervention came only in December of the following year. These requests only occurred after intensive lobbying efforts initiated by the consultant. After again getting started, the collaborative program processed thirty families in each of the next two years. In year 4, the school system signed the consultant to a full-year contract with a monthly check for services. The first family was referred on September 15th. If collaboration is to realize its potential impact on a school system, school leaders will have to be prepared to take on the professional community miscreants whose life pastime it is to find things to complain about and who are, not coincidentally, great candidates for collaborative intervention.

3. Putting your money where your mouth is. One of the principal obstacles facing the collaborative program is funding. While there are state funds for some training, money is not easily justified for collaborative funding. Though a school system can easily access up to $100,000 to send one so-called "learning disabled" or "emotionally disturbed" child to a special private residential school, with dubious results, it finds it almost impossible to find $25,000 to enable a family systems consultant to work with forty families with substantial results and to be available for a full year of general consultation. The prospective "collaborationist" needs to be able not only to demonstrate the superiority of his method but, perhaps even more importantly, to change the allocation procedures in school budgets. Efforts should be made early to engage the support of the superintendent of schools in finding ways to fund the program using existing sources of money. Funding may also be sought outside a particular school system through existing public or private grants or foundations or through approaching private corporations for customized funding. Businesses are spending substantial percentages of their budgets on retraining high school "graduates" in basic skills. Chrysler spends 11% of its total budget in this manner. Businesses like Nabisco are providing millions of dollars in grants to schools which continue to be used primarily for intrapsychic type programs like individual mentoring, career education, or drug education. This money can be redirected to interactional programs through the championing of school leaders.

4. Practice makes perfect. In addition to the informal, indirect training absorbed by participants in collaboration sessions, school personnel need some formal training in how to play the various roles in collaborative interventions. This is particularly true of pupil personnel staff who immediately or ultimately will want to conduct collaborative

sessions without the direction of an outside family systems consultant. It is the belief of this writer that 75% or 80% of child problems can be solved by collaborative communications and interventions with parents by the front-line classroom teacher.

Training in school might also include standard family therapy training methods like the use of the one-way mirror and live supervision. The long-range answer to collaborative skill training for school personnel is curricular offerings at the undergraduate and graduate level and hands-on training during practicum assignments.

5. Even the devil can quote scripture. Although it is clear to most of those involved in collaborative work that it is very effective and probably the best way to go, the need remains for more objective, statistical, and at least semi-scientific evidence of its effectiveness. Pre- and post-intervention analysis, the use of waiting list control groups, and comparison with other approaches need to be employed. With this kind of data, school superintendents and their representatives will more easily allow controversial alternative approaches like collaboration into their schools.

It is even more important, however, for school superintendents to realize that even the devil can quote scripture, i.e., that anything can be proven or disproven with statistics. Given the epidemic of child problems today, schools cannot afford to wait while exhaustive research is conducted and results debated. It is hoped that superintendents can have enough confidence in their own and their staff's judgment to move ahead based on the common sense notions of the collaborative model and a personal exposure to its practice. It is also hoped that parents can be similarly confident in their school staff or insightful enough to realize that the current "blaming the child" approach will never be successful.

6. What's it all about, Alfie? Teachers and other school personnel and parents must be induced into re-examining their goals and procedures. It is no longer sufficient to

simply "do your job" and lament or be indifferent to unsuccessful outcomes. Kids need to be taken care of, and this is not now happening to a satisfactory degree. Leadership from the top must be exercised to target 100% child academic and psychological success in school. School personnel and parents can be inspired. Appropriate staff development conferences and workshops are necessary, as well as the provision of "motivational" tapes and books. It is important to emphasize that the leadership must come from the top. This means superintendents of schools, school board presidents, presidents of PTAs, and mental health association presidents.

Summary

With additional emphasis on the issues of research, training, public acceptance, staff motivation, funding, and support of the consultant, it is hoped that school-based collaboration can achieve in the future the prominence it deserves in school efforts to solve child problems. Perhaps, some day it will be just as much a household word as detention, learning disability, or PPT.

Bibliography

Aponte, H.J. (1976) "The Family-School Interview: An Ecostructural Approach." Family Process, 15, 303-312.

Drucker, Peter. The Effective Executive. New York: Harper & Row, 1967, as summarized in the audiocassette, "The Fast Track." Delran, NJ: Macmillan Book Club, Inc., 1988.

Fine, M.J. (1984). "Integrating Structural and Strategic Components in School-Based Intervention: Some Cautions for Consultants." Techniques, 1(1), 44-52.

Gibbs, Nancy. "Shameful Bequests to the Next Generation." Time, 10/8/90, 42-47.

Haley, J. & Hoffmann, L., Eds. (1968). *Techniques of Family Therapy.* New York: Basic Books.

Hastings, Warren. The Union Leader. 8/07/91.

Kami, Michael, J. Triggerpoints: How to Make Decisions Three Times Faster, Innovate Smarter, Beat Your Competition by Ten Percent (It Ain't Easy). New York: McGraw Hill Book Company, 1988, as summarized in the audiocassette, "The Fast Track." Delran, NJ: Macmillan Book Club, Inc., 1989.

Lusterman, D. (1985). An ecosystemic approach to family-school problems. *The American Journal of Family Therapy*, 13(1)22-30.

Minuchin, S. Families and Family Therapy. Cambridge, MA: Harvard University Press, 1974.

Nicoll, W. (1984). School counselors as family counselors: A rationale and training model. *The School Counselor*, January, 279-284.

O'Callaghan, J. B. (1975). The Community/School/Family Intervention Model. Research report, Georgia State University.

O'Callaghan, J. Brien (1988). "Family-School Consultation, State of the Art Analysis and Blueprint." Workshop presented at the 46th annual conference of the American Association for Marriage and Family Therapy, New Orleans, LA, October 29, 1988.

O'Callaghan, J. Brien (1989). "Collaborative Therapy, Building Bridges Between Home and School." Workshop to be presented at the 47th annual conference of the American Association for Marriage and Family Therapy, San Francisco, CA, October 27, 1989.

O'Callaghan, J. Brien (1990). "Schools Helping Families: Family-School Collaboration." Workshop presented at the 48th annual conference of the American Association for Marriage and Family Therapy, Washington, D.C., October 1990.

Power, T.J. & Bartholomew, K.L. (1987). "Family-School Relationship Partners: An Ecological Assessment." School Psychology Review, 16(4), 498-512.

Tucker, B. & Dyson, E. (1976). The family and the school: Utilizing human resources to promote learning. *Family Process*, 15, 125-142.

Von Bertalanffy, L. (1968). *General Systems Theory: Foundations, developments, applications.* New York: Braziller.

Worden, M. (1981). Classroom behavior as a function of the family system. *The School Counselor*, 28, 178-188.

Appendix

Appendix A

Bibliography of Articles

Appendix B

Bibliography of Tapes

Appendix C

"First the Fire, Then Sweet Corn"

Appendix D

CEU Training Format

Appendix A

School-Based Collaboration
Bibliography of Articles

Amatea, E.S., & Fabrick, F. (1981). Family systems counseling: A positive alternative to traditional counseling. *Elementary School Guidance and Counseling,* 15(3), 223-236.

Amatea, E.S., & Fabrick, F. (1984). Moving a family into therapy: Critical referral issues for the school counselor. *The School Counselor,* January, 285-294.

Andolfi, M., Stein, D.D., & Skinner, J. (1977). A systems approach to the child, school, family and community in an urban area. *American Journal of Community Psychology,* 5(1), 33-43.

Aponte, H.J. (1976). The family-school interview: An ecostructural approach. *Family Process,* 15, 303-312.

Bateson, G. (1972). *Steps to an ecology of mind.* New York: Chandler Publishing.

Blatt, D.O., & Starr, D.A. (1977). A thriving mini-clinic in a school setting. *Social Casework,* 58(10), 585-592.

Braden, J.P., & Sherrard, P.A.D. (1987). Referring families to nonschool agencies: A family systems approach. *School Psychology Review,* 16(4), 513-518.

Brofenbrenner, V. (1977). Toward experimental ecology of human development. *American Psychologist,* 32, 513-531.

Broughten, S.F., Barton, E.S., & Owen, P.R. (1981). Home-based contingency systems for school problems. *School Psychology Review,* 10(1), 26-36.

Caplan, G.(1959). Concepts of mental health and consultation: Their application in public health social work. *Children's Bureau, U.S. Dept. HEW,* 183-211.

Caplan, G.(1969). Opportunities for school psychologists in the primary prevention of mental disorders in children. In A.J. Birdman & A.D. Speigel (Eds.). *Perspectives in community mental health* (422-434). Chicago, IL.: Aldine Publishing Co.

Caplan, G.(1970). *The theory and practice of mental health consultation.* New York: Basic Books.

Carlson, C.I. (1987). Resolving school problems with structural family therapy. *School Psychology Review,* 16(4), 457-468.

Carlson, C.I., & Sincavage, J.M. (1987). Family-oriented school psychology practice: Results of a national survey of NASP members. *School Psychology Review,* 16(4), 519-526.

Carroll, M.R. (1981). End the plague on the house of guidance - make counseling part of the curriculum. *NASSP Bulletin,* 65, October, 17-22.

Carroll, M.R. (1985). School counseling: Dissolution or survival? *NASSP Bulletin,* December, 1-5.

Christensen, O. (1969). Education: A model for counseling in the elementary school. *Elementary School Guidance and Counseling,* 4, 12-19.

Christensen, O. (1972). Family education: a model for consultation. *Elementary School Guidance and Counseling,* 7, 121-129.

Colapinto, J. (1980). The challenge of family therapy. *New York University Education Quarterly,* 11(2), 15-21.

Compher, John Victor (1982). Parent-School-Child Systems: Triadic Assessment and Intervention. *Social Casework: The Journal of Contemporary Social Work,* 415-423.

Conoley, J. (1987). Strategic family intervention: Three cases of school-aged children. *School Psychology Review,* 16(4) 469-486.

Conti, A. (1971). A follow-up study of families referred to outside agencies. *Psychology in the Schools,* 8, 338-340.

Davidson, P.O., Clark, F.W., & Hamerlynck, L.A. (1974). *Evaluation of behavioral programs in community, residential and school programs.* Illinois: Research Press Company.

DiCocco, B., & Lott, E. (1982). Family/school strategies in dealing with the troubled child. *International Journal of Family Therapy,* 4(2), 98-106.

Dien, J.M., van (1988). New parent involvement curriculum field-tested at two AACTE institutions. *AACTE Briefs,* 9(3), 6.

Dombalis, A.O., & Erchul, W.P. (1987). Multiple family group therapy: A review of its applicability to the practice of school psychology. *School Psychology Review,* 16(4), 487-497.

Donigan, J., & Giglio, A. (1971). The comprehensive family counselor: An innovative approach to school counseling. *The School Counselor,* 19, 97-101.

Dorosh, M. (1986). Thistletown's interface programme. *Ontario Psychologist,* 18(4), 8-9.

Dreikurs, R. (1954). Emotional predisposition to reading difficulties. *Archives of Pediatrics*, 71(11), 339-353.

Dunst, C.J., & Trivette, C.M. (1987). Enabling and empowering families: Conceptual and intervention issues. *School Psychology Review*, 16(4), 443-456.

Ehrlich, M.F. (1983). Psychofamial correlates of school disorders. *The Journal of School Psychology*, 21,191-199.

Erchul, W.P. (1987). In guest editor's comments: Family systems assessment and intervention. *School Psychology Review*,16(4), 427-428.

Erchul, W.P., & Conoley, C.W. (1991). "Helpful Theories to Guide Counselors' Practice of School-Based Consultation." *Elementary School Guidance & Counseling*, 25, 204-211.

Esterson, H., Feldman, C., Krigsman, N., et al (1975). Time limited group counseling with parents of pre-adolescent underachievers: A pilot program. *Psychology in the Schools*, 12, 79-84.

Fabrick, F., & Wagner, M. (1981). The story of T.J.: A closer look at school/agency cooperation. *Elementary School Guidance and Counseling*, 15, 188-194.

Feldman, D., Peer, G., & Altman, R. (1984). Implementing family systems therapy in public school settings: Cautions and considerations. *Journal of Child and Adolescent Psychotherapy*, 1(2), 115-117.

Ferrell, Kay Alicyn (1985). Parents as Partners and Advocates. *Journal of Visual Impairment & Blindness*, 203-204.

Fine, M.J. (1984). Integrating structural and strategic components in school-based intervention: Some cautions for consultants. *Techniques*, 1(1), 44-52.

Fine, M.J., & Holt, P., (1983). Intervening with school problems: A family systems perspective. *Psychology in the Schools*, 20(1), 59-66.

Fine, M.J., & Jennings, J., (1985). What parent education can learn from family therapy. *Social Work in Education*, n.d., 14-30.

Fish, Marian C. & Jain, Shashi, (1988). Using Systems Theory in School Assessment and Intervention: A Structural Model for School Psychologists. *Professional School Psychology*, 3 (4), 291-300.

Foster, M.A., Berger, M., Jurkovic, G., et al (1984). *Practicing family therapy in diverse settings.* San Francisco: Jossey-Bass.

Friedman, R. (1969). A structured family interview in the assessment of school learning disorders. *Psychology in the Schools*, 6, 162-171.

Friesen, J. (1976). Family counseling: A new frontier for school counseling. *Canadian Counsellor*, 10, 180-184.

Fuchs, E. (1968). How teachers learn to help children fail. *Transactions*, 5, 45-49.

Gatti, F., & Colman, K. (1976). Community network therapy: An approach to aiding families with troubled children. *American Journal of Orthopsychiatry*, 46(4), 608-617.

Gilligan, J., & Shupack, H.M. (1987-1988). Are delinquency and LD linked?: Two perspectives. *The Tutoring Network Exchange*, (Fall-Winter), 7-9.

Golden, L. (1983). Brief family interventions in a school setting. *Elementary School Guidance and Counseling*, 17, 288-293.

Goldenberg, I., and Goldenberg, H. (1981). Family systems and the school counselor. *The School Counselor*, 28, 165-177.

Goodman, R.W., & Kjonaas, D. (1984). Elementary school family counseling: A pilot project. *Journal of Counseling and Development*, 63, 255-257.

Green, B.J. (1985). Systems intervention in the schools. In M. Mirken & S. Komar. *Handbook of adolescent therapy.* New York: Gardner.

Green, K., & Fine, M.J., (1980). Family therapy: A case for training for school psychologists. *Psychology in the Schools*, 17, 241-248.

Gurman, A., & Kniskern, D. (1978). Research on marital and family therapy: Progress, perspective, and prospect. In S. Garfield & A. Bergin (Eds.). *Handbook of psychotherapy and behavior change: An empirical analysis* (2nd ed.). New York: John Wiley & Sons.

Haley, J. (1984). *Ordeal therapy.* San Francisco: Jossey-Bass.

Haley, J., (1987). *Problem-solving therapy* (2nd ed.). San Francisco: Jossey-Bass.

Hansen, J.C., & Okun, B.F. (Eds.) (1984). *Family therapy with school related problems.* Rockville, MD.: Aspen System Corp.

Hite, M., et al (1985). Family constellations of mentally retarded individuals: The changing role of the school psychologist. *RIE*, October, 1985.

Hobbs, N. (1966). Helping disturbed children: Psychological and ecological strategies. *American Psychologist*, 21, 1105-1115.

Huslage, S., & Stein, J. (1985). A systems approach for the child study team. *Social Work in Education*, 114-122.

Jackson, D.D. (1967). The individual and the larger context. *Family Process*, 6(2), 139-147.

Jayaratne, S. (1978). Behavioral intervention and family decision-making. *Social Work*, 23(1), 20-25.

Johnston, J.C., & Fields, P.A. (1981). School consultation with the classroom family. *School Counselor*, 29(2), 140-146.

Johnston, J.W., Weeks, G.R., & L'Abate, L. (n.d.). *Bronco-busting: Or who is the boss?*, Atlanta, Georgia: Georgia State University.

Kaplan, L. (1971). *Education and mental health*. New York: Harper and Row.

Klein, R.S., Altman, S.D., et al (1981). *Restructuring dysfunctional parental attitudes toward children's learning and behavior in school: Family- oriented psychoeducational therapy*.(2 parts),14 (1&2),15-19, 99-101.

Knox, B.E. (1981). Family counseling: An in-service model. *The School Counselor*, 28, 202-206.

Kramer, J. (1977). Family counseling as a key to successful alternative school programs for alienated youth. *The School Counselor*, 24, 194-196.

London, C.B., Molotsi, P.H., & Palmer, A. (1984). Collaboration of family, community, and school in a reconstructive approach to teaching and learning. *Journal of Negro Education*, 53(4), 455-463.

Loven, M.D. (1978). Four alternative approaches to the family/school liaison role. *Psychology in the Schools*, 15, 553-559.

Lusterman, D. (1985). An ecosystemic approach to family-school problems. *The American Journal of Family Therapy*, 13(1)22-30.

Madanes, C. (1984). *Behind the one-way mirror: Advances in the practice of strategic therapy.* San Francisco: Jossey-Bass.

Madanes, C. (1981). *Strategic family therapy.* San Francisco: Jossey-Bass.

Martin, R.P. (1983). Consultant, consultee and client expectations of each other's behavior in consultation. *School Psychology Review*, 12(1), 35-41.

McDaniel, S.H. (1981). Treating school problems in family therapy. *Elementary School Guidance and Counseling*, 15(3), 214-222.

McGuire, Dennis E., Manghi, Elina R., Tolan, Patrick H. (1990). The Family School System: The Critical Focus for Structural/Strategic Therapy with School Behavior Problems. The Hayworth Press, 107-125.

Miller, D.R., & Westman, J.C. (1964). Reading disability as a condition of family stability. *Family Process*, 3, 66-76.

Minard, S. (1976). Family systems model in organization consultation. *Family Process*, 15, 313-320.

Minor, M.W. (1972). Systems analysis and school psychology. Journal of School Psychology, 10(3), 227-232.

Minuchin, S. (1970). The use of an ecological framework in the treatment of a child. In E.J. Anthony & C. Koupernik (Eds.). *The international yearbook of child psychiatry: The child in his famiy* (183-201). New York: Wiley.

Newman, R. (1967). *Psychological consultation in the schools.* New York: Basic Books.

Nicoll, W., Platt, J., & Platt, A. (1983). Adlerian programs in the schools. In O. Christensen & T. Schramiski (Eds.). *Adlerian family counseling: A manual for counselors, educators, and psychotherapists*, Minneapolis: Educational Media.

O'Brien, C. (1976). A school counselor calls for help. *Journal of Family Counseling*, 4, 75-77.

O'Callaghan, J. B. (1975). The Community/School/Family Intervention Model. Research report, Georgia State University.

O'Connell, J.C., Pfeiffer, J.S., & Pfeiffer, S.I. (1983). Involving parents and families of preschool special needs children in the educational process. *New Jersey Journal of School Psychology*, 2, 54-62.

Paget, K. (1987). Systemic family assessment: Concepts and strategies for school psychologists. *School Psychology Review*, 16(4), 429-442.

Palazzoli, M.S., Boscolo, L., Cecchin, G.F., et al (n.d.). The treatment of children through brief therapy of their parents. *Family Process*, 429-441.

Palmo, A.J., Lowry, L.A., et al (1984). Schools and family: Future perspectives for school counselors. *The School Counselor*, January, 272-278.

Parsons, T. (1959). The school class as a social system. *Harvard Educational Review*, 29, 297-318.

Perosa, L.M., & Perosa, S.L. (1981). The school counselor's use of structural family therapy with learning disabled students. *The School Counselor*, 29, 152-155.

Pfeiffer, S.I., Tittler, B.I. (1983). Utilizing the multidisciplinary team to facilitate a school-family systems orientation. *School Psychology Review*, 12, 168-173.

Phillips, C.E. (1975). Marriage and family counseling in public schools. *Texas Personnel and Guidance Journal*, 4(2), 69-75.

Pierson, E.M., & Whaley, A.L. (1990). Implications of Adult Deveolopmental Stages for School Psychologists' Work with Parents of School-Age Children." *Psychology in the Schools*, 27, 233-237.

Pinsof, W. (1981). Symptom/patient defocusing in family therapy. In A.S. Gurman (Ed.) *Questions and answers in family therapy* , (50-56). New York: Brunner/Mazel, Inc.

Power, T.J. (1985). Perceptions of competence: How parents and teachers view each other. *Psychology in the Schools*, 22, 68-78.

Power, T.J., & Bartholomew, K.L. (1987). Family-school relationship patterns: An ecological assessment. *School Psychology Review*, 16(4), 498-512.

Power, T.J., & Bartholomew, K.L. (1985). Getting uncaught in the middle: A case study in family-school system consultation. *School Psychology Review*, 14(2), 222-229.

Reschly, D.J. (1976). School psychology consultation: Frenzied, faddish, or fundamental. *Journal of School Psychology*, 14, 105-113.

Ron, K., Rosenberg, R., Melnick, T., Pesses, D., (1990). "Family Therapy Alone Is Not Enough or the Dirty Story of Dorian." *Contemporary Family Therapy*, 12, 35-48.

Rueveni, V. (1979). *Networking families in crisis. Intervention strategies with families and social networks.* New York: Human Sciences Press.

Russel, M.L. (1978). Behavioral consultation: Theory and process. *Personnel and Guidance Journal*, 56,346-350.

Sandy, L.R. (1986). "The Descriptive Collaborative Approach to Psychological Report Writing. *Psychology in the Schools*, 23, 395-400.

Sarason, S., et al (1966). *Psychology in community settings: Clinical, educational, vocational, and social aspects.* New York: Wiley & Sons.

Seefeldt, C. (1985). "Parent Involvement: Support or Stress?" *Childhood Education*, 98-102.

Shaw, M. (1969). The feasibility of parent group counseling in the schools. *Elementary School Guidance Counseling*, 4, 43-53.

Shazer, S., de (1982). *Patterns of brief family therapy: An ecosystemic approach.* New York: The Guilford Press.

Smith, A.H. (1978). Encountering the family system in school related behavior problems. *Psychology in the Schools*, 15, 379-386.

Solomon, M.A. (1973). A developmental conceptual premise for family therapy. *Family Process*, 12, 179-188.

Stanton, M.D. (1981). An integrated structural/strategic approach to family therapy. *Journal of Marital and Family Therapy*, October, 427-439.

Stone,G., & Peeks, B. (1986). The use of strategic family therapy in the school setting: A case study. *Journal of Counseling and Development*, 65, December, 200-204.

Stover, N. (1953). The child's learning difficulty as related to the emotional problems of the mother. *American Journal of Orthopsychiatry*, 23, 131-140.

Strother, J. & Jacobs, E. (1986). "Parent Consultation: A Practical Approach." *The School Counselor*, 292-296.

Taylor, D. (1986). The child as go-between: consulting with parents and teachers. *Journal of Family Therapy*, 8(1), 79-89.

Taylor, D. (1982). Family consultation in a school setting. *Journal of Adolescence*, 5(4), 367-377.

Taylor, V., & Hoedt, K. (1974). Classroom related behavior problems: Counsel parents, teachers, or children? *Journal of Counseling Psychology*, 21, 3-5.

Tittler, B.I. & Cook, V.J. (1981). Relationships among family, school & clinic: Toward a systems approach. *Journal of Clinical Child Psychology*, 10, 184-187.

Tucker, B. & Dyson, E. (1976). The family and the school: Utilizing human resources to promote learning. *Family Process*, 15, 125-142.

Von Bertalanffy, L. (1968). *General Systems Theory: Foundations, developments, applications.* New York: Braziller.

Walker, J.R., & Aycock, L. (1984). The counselor as "chicken." *Personnel and Guidance Journal*, 62,424-425.

Warren, R. (1973). The classroom as sanctuary for teachers: Discontinuities in social control. *American Anthropologist*, 75, 280-291.

Wattenberg, S.H., & Kagle, J.D. (1986). School social work referrals for family therapy. *Social Work in Education*, 8(4), 231-242.

Wenger, R.D. (1986). A Longitudinal Study of an Indirect Service Case. *School Psychology Review*, 15, 500-509.

Willan, S., & Hugman, Y. (1982). Family therapy within a school's psychological service. *Association of Educational Psychologists Journal*, 5(8), 48-54.

Williams, J.M., & Weeks, G.R. (1984). Use of paradoxical techniques in a school setting. *The American Journal of Family Therapy*, 12(3), 47-57.

Wolfendale, Sheila (1986). Involving parents in behavior management: a whole school approach. Support for Learning, 1(4), 32-38.

Woody, R.H., Yeager, M., & Woody, J.D. (1990). Appropriate Education for Handicapped children - Introducing Family Therapy to School-Based Decision-Making. *The American Journal of Family Therapy*, 18, 189-196.

Worden, M. (1981). Classroom behavior as a function of the family system. *The School Counselor*, 28, 178-188.

Young, N. (1979). Secondary school counselors and family systems. *The School Counselor*, 26, 247-253.

Appendix B

School-Based Collaboration
Bibliography of Tapes

Institute #12 - 41st AAMFT Conference, Washington, D.C., October 5-9, 1983.
Shazer, S. de et al (1983). Brief family therapy/structural family therapy: What difference do the differences make?

Seminar #123 - 41st AAMFT Conference, Washington, D.C., October 5-9, 1983.
Family therapy in the public school system.
Sachs, B. (1983). Family therapists in educational settings.
Boyle, D. et al (1983). The uses of family therapy in the elementary and junior high schools.
Kurtz, A. et al (1983). Two approaches to family therapy in the schools.

Session #12 - 41st AAMFT Conference, Washington, D.C., October 5-9, 1983.
The setting of family therapy.
Connell, G. et al (1983). A comparison of therapeutic interaction with families in their homes and a professional clinical setting.
Davis, R. et al (1983). The impact of rural community values on the delivery of family therapy in community mental health services.
Norton-Ford, J. et al (1983). Pragmatics of ecosystemics in family therapy practice and training.

Session #13 - 41st AAMFT Conference, Washington, D.C., October 5-9, 1983.
Adolescence
Jessee, E. et al (1983). Staying home therapy: A structural/strategic approach to runaways.
Orchinik, C. (1983). Delinquency - a five-part sequence in family treatment.
Derman, Y. et al (1983). The making of a parent: a paradoxical approach.

Session #317 - 42nd AAMFT Conference, San Francisco, October 18-21, 1984.
School and the family therapist.
Erb, T. (1984). Uses of family therapy in school settings.
Cimmarusti, R. (1984). The family-school matrix: A typology for assessment and intervention.

Session #613 - 42nd AAMFT Conference, San Francisco, October 18-21, 1984.
Implementing Family Systems in the Public Sector: Three Agency Examples.
Ahto, L. et al (1984). Application of the Milan approach in a publicly funded mental health clinic: Clinical and organizational implications.
Byrnes, B. et al (1984). An agency transition from an individual to a family/systems orientation.

Fiman, B. et al (1984). Haley's prescription: Should mental health clinics continue to avoid family therapy?

Session #417 - 43rd AAMFT Conference, New York, October 17-20, 1985.
Brauckman, L. et al (1985). Home-school intervention: A systemic approach to helping families with school-related problems.

Session #513 - 43rd AAMFT Conference, New York, October 17-20, 1985.
Berger, M. et al (1985). Family therapy in context: The effects of treatment setting on the conduct of systemic therapy.

Session #613 - 43rd AAMFT Conference, New York, October 17-20, 1985.
Smith, R. (1985). Family therapy's pejorative view of fathers and fathering: contextualizing family therapy.

Session #620 - 43rd AAMFT Conference, New York, October 17-20, 1985.
Maddock, J. et al (1985). Systems therapy with ecosystems: Multi-problem families and their helpers.

Session #217 - 44th AAMFT Conference, Orlando, Florida, October 23-26, 1986.
School Problems
Miller, V. et al (1986). Successful consultation within the public school settings through strategic interventions.
Vieland, C. (1986). A family-systems approach to persistent school problems.
McGuire, D. (1986). A transcontextual approach to underachievement school problems.

Session #411 - 44th AAMFT Conference, Orlando, Florida, October 23-26, 1986.
Cheatham, S. et al (1986). Application of an integrated model of treatment with children/adolescents and their ecosystems.

Session #552 - 44th AAMFT Conference, Orlando, Florida, October 23-26, 1986.
Pfeiffer, S. et al (1986). Ecosystemic family-school therapy: strategies, issues, precautions.

Session #820 - 44th AAMFT Conference, Orlando, Florida, October 23-26, 1986.
Smith, M. (1986). Ecosystemic treatment of learning disabilities.

Session #828 - 44th AAMFT Conference, Orlando, Florida, October 23-26, 1986.
Peeks, B. et al (1986). The use of strategic family therapy to solve problems in the family-school context.

Session #522 - 45th AAMFT Conference, Chicago, October 29 - November 1, 1987.
Ritchie, A. et al (1987). The family-school intervention team (FSIT): A macro-systemic model.

Session #622 - 45th AAMFT Conference, Chicago, October 29-November 1, 1987.
Little, L. et al (1987). Success with school related problems: A brief, ecological intervention approach.

Session #717 - 45th AAMFT Conference, Chicago, October 29-November 1, 1987.
Family therapy effectiveness:
Vogel, W. et al (1987). A critical review of research studies of the effectiveness of family therapy.
Rickert, Vernon et al (1987). Demonstrating the effectiveness of family counseling within a family service agency: The goal attainment review.
Kelly, P. et al (1987). Comparing individual and family therapy for treatment of adolescents: The presenting problem makes the difference.
Pavlak, M. et (1987). Meeting community needs via family therapy
Cost effective treatment of juvenile offenders.

Session #718 - 46th AAMFT Conference, New Orleans, October 27-30, 1988.
O'Callaghan, J.B. et al (1988). Family-School Consultation.

Session #418 - 47th AAMFT Conference, San Francisco, October 26-29, 1989.
O'Callaghan, J.B. et al (1989). Collaborative Therapy: A Bridge Between Home and School.

Session #716 - 48th AAMFT Conference, Washington, D.C., October 1990.
O'Callaghan, J.B. et al (1990). Schools Helping Families: Family-School Collaboration.

Appendix C

"First the Fire, Then Sweet Corn

Council Crier

In The Frying Pan–

First the Fire, Then Sweet Corn

Back when I was a kid, fall was one of those seasons that had its good and bad points. The humidity was low, but it was cold in the morning. There was football, but then there was school. There was no grass to mow, but there were leaves to rake. Leaf raking at our house was a family chore. The idea was to take one day and get it all done. Well, we were all out there raking and had managed to get the leaves into several large piles. My mother mentioned to my older brother that it was about time to start burning the leaves. Being a six year old, I immediately grabbed a book of matches and lit the first pile on fire.

It was a glorious day for a fire. The sun was shining and there was only a slight wind blowing from the south, so the barn was safe! The fire quickly spread across the lawn to the back field. It raced through three acres of tall grass and into the hedgerow that separated our property form our neighbor's. From the hedgerow, the fire continued across the neighbor's field towards his woods, but the local volunteer fire department arrived and extinguished the blaze.

Our three-acre field hadn't been used in years. It was overgrown and looked worthless to me, but after my scorched earth experiment, it was like new-found land. So my father got the tractor out and plowed the field. The land looked so good that my father decided he would plant something next spring. He decided on sweet corn. Now, three acres of corn is an awful lot for a family of five. We gave away everything the neighbors would take and the rest was eaten by the deer and the raccoons. We never planted sweet corn again.

About 30-something years later, I repeated my scorched earth experiment with my son. No, I didn't burn any leaves — rather, I burned down our relationship. The fire started over homework. He didn't want to do it and I was determined he would! I followed the conventional wisdom that says that incorrect behavior from the child is best handled through a decrease in privileges. We got to the point to where there were few privileges and even less homework. By this time, the field was totally burned.

Conventional wisdom had failed and we were not making any progress. Convinced there had to be a better method, we made an appointment for our family to meet with psychologist Brien O'Callaghan, my son's teacher, and others at the school. This is what Brien refers to as a "family-school collaboration." After two joint meetings at the school and two meetings individually, I became aware of a better path. All the privileges were restored, I got off his back and he started doing his work.

When people encounter severe legal, financial, or physical health problems, they seek assistance from a professional. However, there seems to be a stigma attached to seeking assistance from a psychologist. I guess it stems from the old idea that anyone who visits a psychologist is a "nut." Obviously, I was doing something wrong and the family was suffering, but we found the solution. There are people out there who can help. Believe me, you won't be alone and when you make your first visit; you can discuss it with all your friends in the waiting room.

Appendix D

CEU Training Format

PROPOSAL FOR A
PROFESSIONAL DEVELOPMENT ACTIVITY FOR CEUs

Name of Approved Provider J. Brien O'Callaghan, Ph.D. **Provider No.** ______

Title of Activity Family-School Collaboration:Top Priority for all School Personnel

Name of Presenter(s) (if applicable) J. Brien O'Callaghan, Ph.D.
[ATTACH RESUME(S)]

Need to be Addressed The need for new coordinated, effective, and less expen sive school-based strategies for the resolution of a large number of student academic and behavioral problems not responding to current school policies and procedures.

How was the Need Identified? (optional)
(Check all that apply)

Factual Data [✓ Requested]
Goals/Objectives Anticipated Mandated Felt/perceived
Other (describe) ______

Target Audience (optional) All school personnel, particularly pupil personnel, special education, and administrat

Maximum Enrollment (optional) No limit

Learning Outcomes: As a result of taking part in this activity, participants will

Have:

- Increased ability to understand the meaning and function of many chronic, annoying, or mysterious student academic and behavioral problems
- Increased ability to solve difficult student problems not responsive to other procedures
- Improved team consciousness and functioning within the school building and system-wide

Requirements for Successful Participation:

Because the family is the most influential factor in school performance and behavior, all educators must make family functioning his/her #1 priority. The Family-School Collaboration Model provides a brief, effective, and exciting vehicle for bringing the family and school personnel together for the accurate assessment and resolution of chronic, aggravating, mysterious or life-threatening problems of children of all ages.

PROPOSAL FOR A PROFESSIONAL DEVELOPMENT ACTIVITY FOR CEUS

Design or Outline of Activity (list agenda and time schedule):

Agenda (See detailed agenda attached)

A. Goals	(20 minutes)
B. Assumptions	(20 minutes)
C. Key Concepts	(60 minutes)
D. Implementation	(15 minutes)
E. Blueprint for Successful Child Development (review)	(5 minutes)
F. Preparation of Role Plays	(30 minutes)
G. Simulated Systems Interventions	(150 minutes)
Total Time	5 hours

TOTAL CONTACT HOURS 5
Include only instructional time. See Guidelines for details.

Special Facilities, Equipment or Materials to be used Overhead projector

Evaluation Methodology (Check all that apply): ___Reaction survey ___Discussion

___Followup Survey ___Observation ___Statistical Analysis

___Other (describe) ____________

Will a followup activity to this proposed one be offered? (optional) ___Yes ___No

If Yes, please provide a brief description below:

Ideally, for participants to become competent in the utilization of the procedures recommended in this workshop, they should participate in actual school-based collaboration sessions conducted by this presenter with real students, families, and school personnel. Case conferences or other follow-up staff development formats should be also provided.

NOTE: If the above activity is offered for CEUs, this form, the attached resume(s), the form completed after reviewing the proposal, and the form completed after the activity has taken place, must be available to the state department of education on request any time up to three years after the completion of the activity.